Pure Resolutions LLC

Notice of Independent Review Decision

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PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. The mechanism of injury was not available in the records. The diagnoses were X. X was evaluated by X, DO on X for a follow-up. X seemed somewhat agitated due to the persistent nature of X. X stated the medicines as X spoke of them as a whole, were causing X. X had X. X was mostly efficacious and the plan was to continue X on that. X was also to start X. The plan was to proceed with a X. In a follow-up note dated X, Dr. X commented that X and X did not understand why the treatment was denied. At the time, X was quite anxious. X had X. X was walking once again with an X. X had a X. The plan was to submit for an appeal for X. An MRI X dated X identified possible X. A drug adherence assessment report dated X was negative. Treatment to date included medications including X. Per a Notification of Adverse Determination dated X, the request for X was non-certified. Rationale: "Per evidence-based guidelines, X are recommended as a short-term treatment for X. A request for the procedure in a patient with X requires additional documentation of X. X are not routinely recommended unless there is evidence of an X. X is not generally recommended but when required for X, the patient should X. In this case, the patient presented with X. X had X. X MRI of the X dated X noted there may be an X. There was an X. A request was made for X. However, given the age of injury, clarification is needed if this is for an X as it was unclear from the medical reports submitted. If this is for initial, the medical reports submitted were limited to establish failure from X such as X and to warrant the need for this request. Furthermore, recent symptom progression of X was not objectively and comparatively measured from the limited clinical reports presented. If this is for a X, clarification is also needed as to when the X was made which is specifically targeted to the X as guidelines restrict X to patients with continuous X. Additionally, X response to the prior X.

Clarification is needed with respect to the requested treatment and how it might affect the patient's clinical outcomes. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is not medically necessary. In light of this presenting issues and in the absence of pertinent extenuating circumstances that would require deviation from the guidelines, the request for X is not MEDICALLY NECESSARY as clarification is needed if this is for an X as it was unclear from the medical reports submitted." A Notification of Reconsideration Adverse Determination dated X indicated that the appeal for X was denied. It was determined that based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request was not certified. X was not noted. Clarification was needed regarding whether this would be an X.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

This patient presents with X. The following factors are evident; the clinical picture is that of a X has failed, the MRI findings correlate with the clinical picture, the recommended intervention is an attempt to avoid surgery, two prior reviews were unable to determine whether this is X and used this as the basis for the denials. However, the records show that this is not a X. The patient is compliant for X. The need for X during the procedure has been documented.

Given the documentation available, the requested service(s) is considered medically necessary.

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL