

**Clear Resolutions Inc.**  
**An Independent Review Organization**  
**3616 Far West Blvd Ste B**  
**Austin, TX 78731**  
**Phone: (512) 879-6370**  
**Fax: (512) 572-0836**  
**Email: [resolutions.manager@cri-iro.com](mailto:resolutions.manager@cri-iro.com)**

***Information Provided to the IRO for Review***

- Clinical Records – X
- Work Status Note – X
- Texas Workers' Compensation Work Status Report – X
- Utilization Reviews – X
- Diagnostic Data Report – X

***Patient Clinical History (Summary)***

X is a X-year-old X who was injured on X. X was involved in a X. X hit the X on the X. X was also X. X was diagnosed with other X, current injury, X, initial encounter (X).

On X, X was evaluated by X, MD for the X pain. The examination showed a positive X sign. There was X, and pain with full X of the X.

An MRI of the X dated X revealed X in the body and X of the X, concerning for X ; X injuries of the X.

Treatment to date included medications (X), X intervention (X), and X.

Per a utilization review determination letter by X, DO dated X, the request for X was denied. It was determined that with regard to the requested X, the request was not supported. The clinical documentation indicated that X continued to complain of X pain. In addition, there was a positive X on physical examination of the X. However, there was lack of documentation indicating that X had exhausted all conservative

***Notice of Independent Review Decision***

Case Number:

Date of Notice: 07/02/19

treatments. Furthermore, there was no documentation of an MRI submitted for review. There were no exceptional factors documented to support the requested treatment. As such, the requested X was non-certified.

A utilization review appeal denial letter dated X indicated that the reconsideration request for X was denied / non-certified. There was an appeal for the previously denied request. X non-certified as the request was not supported. There was a lack of documentation indicating X had exhausted conservative treatments. There was no documentation of an MRI submitted for review. There were no exceptional factors documented to support the requested treatment. The Official Disability Guidelines recommended X for symptomatic X in XX patients. Not recommended for XX in the absence of major mechanical locking or for XX patients with XX X or more appropriately treated with physical therapy / exercise. Whether or not X surgery was performed, X increased the risk of subsequently developing XX (OA) by up to 5.7 times. The criteria for X required two symptoms into signs to avoid lower yield surgery. Physical therapy, supervised physical therapy and / or home rehabilitation exercises with compliance and medications. The medical records submitted for review did not include whether physical therapy had been completed and had not been for at least six months as per the guideline recommendation. As such the request for X was non-certified.

***Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.***

The ODG recommends X when there are at least two pertinent subjective complaints, at least two pertinent objective clinical findings on physical examination, imaging findings of a X, and a treatment failure with physical therapy in addition to medication or activity modification.

***Notice of Independent Review Decision***

Case Number:

Date of Notice: 07/02/19

The provided documentation indicates a subjective complaint of X pain. There are no other documented subjective complaints. There are physical examination findings of an X, and a positive X test. An MRI has confirmed a X. There is evidence of persistent pain despite treatment with X modification. However, while the note from X suggests the injured worker has tried X, there are multiple documented injuries, and it is unclear of physical therapy included the X. In addition, the number of physical therapy visits completed is not documented. Based on the lack of documentation regarding treatment with physical therapy, the request for X is not medically necessary.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ACOEM-America College of Occupational and Environmental Medicine
- AHRQ-Agency for Healthcare Research and Quality Guidelines
- 
- DWC-Division of Workers Compensation Policies and 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 and Treatment Guidelines
- Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- Texas TACADA Guidelines

Clear Resolutions Inc.

***Notice of Independent Review Decision***

Case Number:

Date of Notice: 07/02/19

- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Medical Literature (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

**Appeal Information**

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:  
Chief Clerk of Proceedings Texas Department of Insurance  
Division of Workers' Compensation P. O. Box 17787  
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.