Pure Resolutions LLC

Notice of Independent Review Decision

Case Number: Date of Notice: 6/24/2019 10:42:05 AM CST

Pure Resolutions LLC
An Independent Review Organization
990 Hwy 287 N. Ste. 106 PMB 133
Mansfield, TX 76063
Phone: (817) 779-3288
Fax: (888) 511-3176
Email: brittany@pureresolutions.com

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: • Clinical Records –X
- Appeal Letter –X
- Peer Reviews –X
- Utilization Reviews –X
- Letter –X

PATIENT CLINICAL HISTORY [SUMMARY]: X is a X-year-old X who suffered an on-the-job injury on X when X was involved in an X. X also underwent an X due to XX in X. X ongoing diagnoses were X, other abnormalities of X, X, X , unspecified affecting X, X, X, unspecified joint, other lack of coordination, X, X, other X, X, X, unspecified X, X following X and unspecified X. On X, X. X was evaluated by X, MD. X suffered an on-the-job injury on X while working with "X" when X was involved in an X resulting in X. X residual injuries included X, X, X with residual X , X, X, X, and X. X was status post X and X due to fall in X. X required a maintenance program to maintain X ongoing mobility. X did not XX in the XX unless X was with physical therapy. X X was able to XX assist with XX and all X activities of daily living but if X became X from XX, then X was at X with potential for X. This had already occurred in X where X was hospitalized for X status post X due to XX at XX. X used X X to the X when X was XX with assistance; otherwise, X was in X. Treatment to date consisted of medications (X), X and X to the

X, and X (X, X, X, and X. Per a utilization review determination letter dated X by X, MD, the prospective request for unknown X evaluation and treatment for X, frequency and duration unspecified, as outpatient between X and X was non-certified. Per an addendum note, after a phone call with Dr. X, it was noted that eight weeks of therapy, three times weekly was being requested. Dr. X noted that additional information would be faxed. Dr. X noted that at the time of the request, no additional information was received or discussed to support the request. The request was noncertified with the following rationale: It was determined that the Official Disability Guidelines recommended X for claimants with a diagnosis of a X resulting from injury, X, or X. X. X had been participating in therapy on an ongoing basis for rehabilitation, in order to regain range of motion and prevent decline. The documentation stated that X had prior X, and had been attending therapy. The provider noted that additional therapy was being recommended. However, the request was submitted for evaluation and treatment, and the frequency and duration of intended treatment was not specified. Also, X. X had an extensive history of prior rehabilitation, but there were no XX therapy notes provided or rehabilitation summaries to identify specific improvements as a result of prior therapy. Given the above, the request was not supported. X evaluation and treatment for X, frequency and duration unspecified, as outpatient was not medically necessary. Per a letter dated X, Dr. X documented that X. X had been under XX care and continued to have long-term disabilities following a X injury with X which included X accident times three with X, X times five, acute X injury greater than X, X, X, X, X, X pain X. X had X and would be benefited from an 8- to 12 week outpatient rehabilitation program to address X decline in functional ability to perform XX-XX XX and XX XX, assist with XX tasks for activities of daily living and ongoing XX rehabilitation for XX finding X. At the time, X was unable to XX with the assistance of X X alone and required XX-XX XX. Due to X, X would always XX XX for safety. X. X had been without any therapies, and X was having increasing difficulty with X. X was at risk for further X as well as XX XX due to the nature of X X injury. A reconsideration review letter dated X by X, DO indicated that the prospective request for unknown reconsideration for X and treatment for X and word-X, 8-12 weeks (frequency unspecified), as outpatient between X and X was noncertified. Rationale: “X. X has had extensive X since X initial injury and according

to the medical records reviewed, X functional capabilities have not improved in spite of the extensive X and in spite of the extensive treatment that X has had for X debilitating condition. The request at this time is essentially an extensive rehabilitation program involving all of X and the medical records indicate that the goal is to prevent further deterioration." Dr. X also opined that the requested service was not medically reasonable, necessary or appropriate. X. X had an extraordinary amount of X with no significant improvement. X did interact with X family as best as X was capable, and there had been no significant improvement in X XX function.

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

This is a chronic case dating back X years with a complex injury involving an X enduring a X and also a history of a X. This patient has received extensive prior physical medicine treatment. The medical records at this time do not clearly discuss specific goals for additional physical medicine treatment. The rationale for resuming such treatment is not apparent at this time.

Given the documentation available, the requested service(s) is considered not medically necessary and the decision is X.

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

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☒ 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

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL