# Clear Resolutions Inc.

**An Independent Review Organization**
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## *Review Outcome*

***Description of the service or services in dispute: X***

***Description of the qualifications for each physician or other health care provider who reviewed the decision:***

Board Certified Orthopedic Surgery

***Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:***

- ☐ Overturned (Disagree)
- ☑ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

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

- Clinical Record X
- Notice of Adverse Determination X
- Appeal/Reconsideration of Adverse Determination – X
- Attorney Letter – X
- Diagnostic Data Reports – X

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

X. X X is a X year-old X with date of injury X. X X X and hurt XX XXX and X. The diagnoses were X, X X, and X.

On X, X. X was seen by X, MD after an X. X complained of pain in the X and XX X and X. On examination, the flexion and extension of the X X was 45 degrees, Xl rotation was 45 degrees, and X was 60 degrees. The X X was 80 degrees, extension was 10 degrees X rotation was 45 degrees, and X was 45 degrees. X sign was positive.

An x-ray of the X X date X showed X.

Per an Adverse Determination dated X, the request for MRI X of the X X was denied. X MD stated that “Request is not medically necessary. Per conversation with Dr. X, this request does not meet the criteria for approval as there was no documentation or details given of the most recent plain films.”

Per a Reconsideration / Appeal of Adverse Determination dated X, X, MD stated that “The following request has been reviewed by a physician advisor and has been determined not medically necessary. The request is not supported and does not meet ODG. Recommend denial.” A peer to peer was conducted with Dr. Xl who refused to give any information to support X request for MRI, stating that X. X was having X of the X and that the insurance was not entitled to know anything about his patient. Dr. X tried to explain that X request as submitted without any medical records failed to meet ODG and his refusal to give explanation in the discussion was not helping X. X. The request was not supported and did not meet ODG. Denial was recommended.

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## *Notice of Independent Review Decision*

Case Number: Date of Notice: 06/05/19

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

Based on the clinical information provided, the request for MRI X X without contrast is not recommended as medically necessary, and the previous non-certifications are X. There is insufficient information to support a change in determination, and the previous non-certification is X. There are no prior imaging studies/radiographic reports submitted for review. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no clear rationale provided to support the request at this time. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

***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
- ☐ 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**

## *Notice of Independent Review Decision*

Case Number: Date of Notice: 06/05/19

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.