

**Pure Resolutions LLC**  
***Notice of Independent Review Decision***

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**PATIENT CLINICAL HISTORY [SUMMARY]:** X who was involved in a X accident and injured on X. X was X. X was diagnosed with X. X was evaluated by X, MD on X, for a follow-up on work-related X. X continued to have X at the time. X stated that X tried not to over-X. X rated the pain X. X weight was X pounds and body mass index X. On examination, X appeared uncomfortable. There was X. Dr. X recommended X. A DWC Form-73 was completed, which allowed X to return to work as of X, with restrictions, which were expected to last through X. The activities restricted were X. The restrictions were specific to the X. X was allowed X. X underwent a functional capacity evaluation (FCE) on X by X, PT, to objectively quantify the ongoing maximum voluntary physical capacity of X ability to perform functional activities in a structured setting. The pain was rated X, pre-FCE and X-FCE. X opined that X qualified as medium under the physical demand level of work, as defined and outlined in the dictionary of occupational titles. X was instructed in appropriate body mechanics for X. X demonstrated good body mechanics and was able to apply and carry out instruction without difficulty. X also presented a cooperative attitude throughout X evaluation. X previous medical treatment had included visits with X when necessary for a total duration of about X months. X total perceived benefit in that time had been rated as X. X was at the time, back at work, however, X was restricted to light duties at the time. X ongoing complaints included X. X stated X symptoms were aggravated with X. X stated X symptoms were X. X also stated X felt limited in various aspects of X life including X. An MRI of the X dated X was unremarkable. Treatment to date included X. Per a Utilization Review Determination Letter dated X by X, MD, the recommended prospective request for X was non-certified. Rationale: "In this case, the patient presented with X. The patient reported feeling better with X. On examination of the X, an active X. The strength of X. On examination of the X, active

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X. The strength on X, the patient had X. Upon palpation, there was muscle tightness noted on X. However, duration of prior X is unknown. There is no indication the patient cannot address any remaining deficits with a X. Furthermore, positive exam findings pertain to the X.” Per a Reconsideration Review Determination Letter dated X by X, MD, the recommended prospective request for X was non-certified.

Rationale: “The Official Disability Guideline recommends X. The recommendation is for X. In this case, the patient continued to complain of X. Upon physical examination, the strength was X. There was stiffness upon palpation to the X, however, the request was previously denied due to lack of documentation of the previous sessions of X. The documentation submitted for this review did not provide information regarding the previous X. There is no documentation provided of significant X. There is no documentation provided on why the patient cannot continue a X.”

#### **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 X is not recommended as medically necessary, and the previous denials are upheld. Per a Utilization Review Determination Letter dated X by X, MD, the recommended prospective request for X was non-certified. Rationale: “In this case, the patient presented with X. The patient reported feeling better with X. On examination of the X, an active X. The strength of X. On examination of the X, X. The strength on X. However, duration of prior X is unknown. There is no indication the patient cannot address any remaining deficits with a X. Furthermore, positive exam findings pertain to the X.” Per a Reconsideration Review Determination Letter dated X by X, MD, the recommended prospective request for X was non-certified. Rationale: “The Official Disability Guideline recommends X. The recommendation is for X. In this case, the patient continued to complain of X. Upon physical examination, the strength was X, the special testing included X. There was stiffness upon palpation to the X, however, the request was previously denied due to lack of documentation of the previous X. The documentation submitted for this review did not provide information regarding the previous X. There is no documentation provided of significant residual functional

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deficits remaining due to the X. There is no documentation provided on why the patient cannot continue a X.” There is insufficient information to support a change in determination, and the previous non-certification is upheld. The total number of X visits completed to date is not documented. Current evidence-based guidelines do not generally support the utilization of passive treatment modalities such as X. There are no contraindications to a X documented.

Given the documentation available, the requested service(s) is not medically necessary. The request is upheld.

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

- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES