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**PATIENT CLINICAL HISTORY [SUMMARY]:**

X who sustained an injury on X. X was a X. They were X. It caused X to X. X. X was diagnosed with X. X, MD evaluated X on X for X. X was status X on X. X had undergone X on X with X. X was concerned because the X. X pain. X pain. The X examination revealed X. Per a DWC Form-69 dated X by X, MD, X had not reached MMI, but was expected to reach MMI on or about X. X-rays of the X dated X showed status X. The treatment to date included medications X. Per an Adverse Determination letter dated X, the request for X was denied by X, MD. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is noncertified. Per evidence-based guidelines, X is recommended as indicated only for X. X is only recommended for complications following X. In this case, the patient returned X weeks follow up for X on X. X stated that the X only provided X, X was concerned because the X. On examination of the X was not present. X was present in the X. A request for X with X to Evaluate X was made. However, clarification is needed if the current request is a X. If so, there was no evidence of X. Exceptional factors that might deviate the guidelines recommendations were X. As the medical necessity of the requested X was not established, the X is also not warranted at this time." Per a Utilization Review decision letter dated X by X, MD, the request for X was noncertified. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The patient does have X. However, the request also includes X. The indication for these codes X. The entirety of the request is thus not supported."

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

The ODG supports X. X with persistent mechanical symptoms when there is been

a X. X is supported for X. X is supported for X in the X. X are supported following X or for documented X. The documentation provided indicates that the injured worker has had X. Additionally, the injured worker has had X. A recent X examination documented X. The treating provider has recommended a X. Based on the documentation provided, the requested X would not be considered medically necessary as there is X. Additionally, there is no imaging documenting a X to support the need for X. As X is not medically necessary, X would not be medically necessary.

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

**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