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 X

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

X

Patient Clinical History (Summary)

X who was injured on X. The biomechanics of the injury was not available in the records. X was diagnosed with X.

Following the X on X for diagnosis of X, X underwent X under the care of X, PT, DPT. On X, X reported X. However, X continued to have X. On examination, there was X. However, X was felt to be X. Additional X was therefore recommended.

On X, X, DO saw X in a follow-up for X. X date of X was X. X rated X pain at X, with X. X was in the X. X had been X. The assessment was X. Dr. X recommended X. X was to X.

Treatment to date included X.

Per Utilization Review dated X, the request for X was denied. Rationale: “A medical document dated X indicated that subjectively, there were symptoms of pain described as X. Objectively, there was an ability to X. Reportedly, previous treatment has included at least in total, X. For the described medical situation, the above-noted reference would not support the medical necessity for this specific request as submitted. The requested amount of treatment in the form of X. Additionally, the X. Consequently, presently, medical necessity for additional treatment in the form of X is not established. Recommend non-certification. The screening criteria and treatment guidelines used to make this determination: ODG X.”

Per the reconsideration letter dated X, X MD upheld the denial for the request for X as it still did not meet the necessary guidelines. Rationale: “According to the Official Disability Guidelines, X is recommended for X. Denial documentation dated on X revealed that the request for X was noncertified due to the requested amount of treatment in the form of X. The patient had completed X. The patient continued to note X. X examination X noted an X. X testing noted X. X were noted as X. X testing included a X. However, the current request would exceed the recommended number of allowed X for the patient's current diagnosis to warrant the medical necessity of X at this time. As such, the request for X is non-certified.”

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

The ODG recommends up to X. The ODG does not recommend X. The provided documentation indicates the injured worker X. Per the provided X progress note, X. Per the most recent clinical progress note from X, there is persistent pain rated at X. The injured worker continued to X. Per the X order from X, the provider recommended X. Based on the available information, the ODG would support X. Recommendation is to X. Given the documentation available, this portion of the requested service(s) is considered 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
- ☐ 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.