Clear Resolutions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 CR
Austin, TX 78731
Phone: (512) 879-6370
Fax: (512) 572-0836
Email: @cri-iro.com

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 with a date of injury X. X was injured while X. X was diagnosed with X.

X was seen by X, MD on X for X. X continued to X. The pain X. X experienced X. The pain was X. The symptoms were X. The X.

An X was performed on X. The X was X. This was a X. In addition, X in the X. On X, there was X. X had pain with X.

An MRI of the X showed a X with X. There was X. X were noted. A X was likely at X. This was X incidentally noted.

The treatment to date included X.

Per a Utilization Review decision letter dated X, MD, the request for X was denied. Rationale: X is not recommended as per the guidelines. Also, this device is supposed to be used in X. There is X. X of X. X other X. were documented. Therefore, there is X. There is X. The X showed X. The X and X. The X that there is X. The X both documented that X, and there was X. Because the X and requested X are not medically necessary there is no indication to X. Also, there is X. Regarding only X. X is correct for the requested X for the requested X is not correct because X and they are X is not correct because X was not requested and even if it was it should be submitted only X is not correct because X as this was not included in the request. Recommend noncertification."

Per an Adverse Determination letter dated X, the prior denial was upheld by X, MD. Rationale: "The ODG by X does not recommend X is recommended as an option for X. X is not recommended as a routine procedure. It is recommended for X. In this case, the patient complained of X. The patient X. On examination, there was X. The X. There was X. There was X noted of the X. The request was previously denied due to the X. There is no X. There was no additional documentation provided for this review. The X and examination were not provided. Based on the prior review, there is no indication for X. The guideline does not support X. X does not allow for modification of orders without a peer-to-peer discussion and agreement from the prescribing physician, 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 claimant has a X. Recent imaging of the X found no evidence of X. The MRI studies of the X detailed no significant X. At X there was no evidence of any X would be indicated. No other X were noted that would support proceeding with X. The overall benefit from further X is still unclear vs. X. Therefore, it is this reviewer's opinion that medical necessity is not established and the prior denials are upheld.

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)