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 who was injured on X. The mechanism of injury was not provided in the records. The diagnoses included X.

On X, MD evaluated X via telemedicine for X. X rated X pain a X. X stated that X. X were refilled.

A X report dated X PhD indicated that X presented with evidence of X. Dr. X that X was a X. Dr. X noted that X.

An MRI of the X showed X.

Treatment to date included X.

Per a Utilization Review dated X, the request for an X was non-certified. Rationale: “According to a X, there was documentation of the claimant having X. There was also documentation that the current X. According to a X. The provider also reported that the claimant has history of X is being

requested to help determine if this might provide X. However, with no indication of the claimant's X. Therefore, the request for the X is non-certified."

On X presented to Dr. X to appeal the denial of X. X rated X pain X. X had X. X was X. X had had X. The X managed X. Examination showed X. The plan was to do an X.

On X the appeal for X was non-authorized. Rationale: "ODG-TWC notes that X are recommended as indicated below on a case-by-case basis as a third-line, last resort treatment for X. Indications include X. The pain source addressed with X. A X should be performed by an X. X is not recommended for X. Case discussion notes that the claimant has X. Dr. X states that the claimant has X. The provider states that the claimant is X. Dr. X states that the rationale for the X. The provider states that the claimant wishes to X. In this case, the medical necessity of requested procedure is not established. The documentation reviewed indicates that X. Also, there is limited evidence on exam that supports significant X related to X, and the MRI X. X is not recommended as a X. As such, recommendation is to deny."

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

The patient presents with X. The rationale for the X is not clearly stated in the provider's medical records. A diagnosis of X is not clearly stated in the provider's X. The medical records also stated that the current X. While the X, the ODG X, as corroborated by two prior utilization reviews. Given the documentation available, the requested service(s) is considered not 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)