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

Notice of Independent Review Decision

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

Information Provided to the IRO for Review
X

Patient Clinical History (Summary)
X is X who injured X on X. X was at X. X was X and X took a X and X. Later, when X closed the X, X noticed X and X. The diagnoses were X, pain in the X, and, X, X. X visited X, DO on X for further evaluation of X. X stated that X attended a X and X. X had X, but X could not perform X with the X. On examination, there was X. X had a X. The X was X. An X was X. There was X. X had a X at X on X. X reported X and X that was described as X and X. X exhibited pain; X; X and X. Treatment to date included X, and X. Per a Utilization Review decision letter dated X and peer review dated X; the request for X, X was denied by X, MD. Rationale: “In this case, the claimant had X and X, X. Per records of X, X had X. X continues to have X. However, X notes X had X. X appears to have X that are X. Moreover, the X that X had X to date. I was unable

to reach the X to clarify the number of X to date. Therefore, at this time, X are not medically necessary."

Per an Adverse Determination Letter dated X and peer review dated X by X, MD, the prior denial was upheld. Rationale: "The provided documentation does not describe the X. The claimant may have had X. In either case, the request for X exceeds guidelines. Although, the claimant still had X needs to be clarified before determining if further X is indicated. Therefore, an appeal for X for X is not medically necessary."

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

The ODG recommends up to X. The provided documentation indicates the X. X have reportedly had X. There is no evidence the X would be X, which X in following X, and there is X the guideline recommendation for X. Based on available information, X for the X is not medically necessary. Recommendation is to uphold the two prior denials.

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)