Pure Resolutions LLC

An Independent Review Organization
990 Hwy 287 N. Ste. 106 PMB 133
Mansfield, TX 76063
Phone: (817) 779-3288
Fax: (888) 511-3176
Email: @pureresolutions.com

Notice of Independent Review Decision

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: X

REVIEW OUTCOME:

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 a X who sustained an injury on X. X, X and X and X. The diagnoses included X. X was seen by X, on X. X presented with X. Dr. X went over X prior history including X. As a result, all roads led to X. The X of this clinical diagnosis had already been confirmed by X and others. X noticed X with a combination of X. X had X. On X, X reported X. X showed X. X had X. X had X. The X had X to the X. X was X. X showed signs of X. X and X were X. On X, X was seen in a X. X reported X. X rated the X. X had X and X. X was performed by X, on X. It showed that X had reached X on X with X. X evaluation was performed by X, on X. X complained of X. Those X were X by X. X were made X by X. X rated the pain X. The X was X. X was X. X could X. In summary, X had X during the X. X appeared to be X. The X were demonstrated during X. X demonstrated X. X demonstrated the X to X. X was X.

An X of the X dated X demonstrated X. No X was noted. There was no significant X. An X of the X dated X demonstrated X. X dated X was X for X. Treatment to date included X. Per a utilization review by X, MD on X, the request for X was non-certified. 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 guideline does not recommend X." Per a utilization review by X, MD on X, the request for X was non-certified. 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 guidelines stated that X."

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

Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review by X, MD on X, the request for X was non-certified. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The Official Disability Guidelines note that the requested procedure is not recommended based on a lack of quality studies. Since X, despite lack of evidence of effectiveness, other more proven treatment strategies X should be preferentially instituted. There is no documentation of X.

Therefore, medical necessity is not established in accordance with current evidence based guidelines.

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