Pure Resolutions LLC

An Independent Review Organization
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Notice of Independent Review Decision

Sent to the Following

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 with date of injury X. X was involved in a X. While at X was the X which was X and X and then was X and told that the X was in X and then X. The diagnoses were X. On X, X, NP / X, MD evaluated X for X and X. The X was X and X. The pain was X. X also had X. On examination, X had X to X. There was X, and X. On X, X, MD evaluated X for X. X was X. The pain was located at the X. The pain radiated into the X. The quality of pain was X and X, and X. The X. The aggravating factors included X. The pain was X. Alleviating factors included X. X was X. On examination, X was in X. X was X There was X of the X. X of the X revealed X. X revealed X and X. X was within X. A X of the X and a X and X revealed X; however, X, and X. A X of the X revealed X. X of the X revealed X. There was X. There was X. Treatment to date consisted of X. Per a utilization review dated X, request for X

was denied by X, MD. Rationale: “Per ODG, “Not recommended for X. The patient was injured in a X. Guidelines do not support this procedure for X, as in this case. This procedure is only recommended as an X. This request is not medically necessary.” As the X was not indicated, therefore rest of all the requests were not medically necessary. Per a utilization review dated X, X, MD denied the requested services of X. Rationale: “Per ODG X- online version X Not recommended for X. A successful peer conversation has occurred, there has been a previous adverse determination for this request. The guidelines do not support its use for a X. A peer review did occur however, no new information was provided to support this requested procedure.” The screening criteria for the denial was “Official Disability Guidelines – X, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with X]”

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

The claimant X. No X were detailed on X. The claimant was treated with X; however, there was no documentation that the claimant had X.

Given the limited evidence in the current literature regarding the efficacy of X in X, it is this reviewer’s opinion that medical necessity for the X request X is not established.

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