Pure Resolutions LLC
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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 was injured on X. X injured X. The diagnosis was X. On X, X was evaluated by X, MD. X complained of X. X was X. On examination, there was X. There was X in the X on the X at X and X. The assessment was X were recommended. On X, X was seen by Dr. X for complaints of X rated X with the X. X was X. An X of the X dated X revealed X. There was X and X. At X, there was X. The X was X. There was X. At X, there was X. There was X. There was X. There was X. The X. At X, there was X. There was X. The X were X. At X, there was X. There was X. There was X. The X was X. An X study dated X demonstrated X. There were X at the X, X of X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. The reviewer noted there was X request for X, X which was not certified, thereby precluding the medical necessity of the above request with X. Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X was denied. The reviewer noted X was X and

there was X; however, there was no clear evidence of 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. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The X is not X. X evaluation indicates that X needs X. Anticipated X date is X. Current evidence based guidelines note that X may be grounds to X of X and is only to be considered for X. It appears there have been no active treatment modalities in X. X notes X at the levels of X, 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