Clear Resolutions Inc.
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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

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:

☐ Overturned (Disagree)

☐ Partially Overtuned (Agree in part/Disagree in part)

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states

whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X was injured while X. The diagnosis was cervicalgia; spondylosis without myelopathy or radiculopathy, cervical region; other long term (current) drug therapy; chronic pain syndrome and; post laminectomy, cervical region. There were no office visits available in the provided medical records. Treatment to date included X.Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "No, the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. Official Disability Guidelines conditionally recommends X. Guidelines indicate X. Physical exam of cervical spine noted X. Treatments have included X. While the claimant may benefit from the request, records X. Therefore, the request of X, is non-certified. "Per a reconsideration / utilization review adverse determination letter dated X, the request for X was denied by X, DO. Rationale: "No, the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. The Official Disability Guideline recommends X. The guidelines recommend X. The guideline X. On X, the claimant was seen for follow-up for continued neck pain and headaches. The claimant had X. The claimant rates the pain X with medications and X without medications. On the physical exam, X noted on the left side and right side. X decreased. Pain is reproduced with X. There was X. X-ray of cervical spine dated X showed X. The provider recommended X. However, the prior denial reasons have not fully been addressed within the documentation. While radiographs were provided for review, the

records did not indicate whether the claimant had previously undergone the procedure in the past. As X are not recommended prior to X. As such the request for X is non-certified. “The requested X are not medically necessary. A MRI imaging reports has not been submitted for review to rule out potential other sources of pain. In addition, the types of X has not specified. No recent therapy reports have been submitted for review to determine X. No new information has been provided which would overturn the previous denials. X are not medically necessary and non certified

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

The requested X are not medically necessary. A MRI imaging reports has not been submitted for review to rule out potential other sources of pain. In addition, the types of X previously administered has not specified. No recent therapy reports have been submitted for review to determine X. No new information has been provided which would overturn the previous denials. X are not medically necessary and non certified
Upheld

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**

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

☐ **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**

☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)**