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

Amendment X

REVIEWER REPORT

Date: X; Amendment X; Amendment 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 Overturned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X when X was X. X. The diagnoses were low back pain; other intervertebral disc degeneration, lumbar region; other intervertebral disc degeneration, lumbosacral region; other intervertebral disc displacement, lumbar region; intervertebral disc disorders with radiculopathy, lumbar region; intervertebral disc disorders with radiculopathy, lumbosacral region; and spinal stenosis, lumbar region without neurogenic claudication. On X, X was seen by X, MD for follow-up visit for evaluation of low back pain. X reported X pain started after completing a physically demanding work site through X job. X continued having low back pain X. On examination, blood pressure was 134/91 mmHg, weight was 120 pounds and BMI was 34.96 kg/m2. Back examination revealed X. The neurological examination revealed X. The sensory examination revealed X. The X was X. Dr. X noted that X had tried X. X lumbar X demonstrated X. Since X prior visit, X now had a X. X had tried literally every nonoperative modality, and further nonoperative treatment would not be expected to improve X since X needed a X. Dr. X recommended X, which would be a X. Treatment to date X. Per a utilization review adverse determination letter dated X and peer review report dated X, the request for X was denied by X, MD. Rationale: “The request for X is not medically necessary. ODG clearly state criteria that should be met, but this claimant's exam shows X. While Dr. X did convey that the claimant has symptoms, there isn't documentation of a X. Therefore, the request for X is not medically necessary.” Per a reconsideration review adverse determination letter dated X and peer review report dated X, the request for X was denied by X, MD. Rationale: “X is not medically necessary. Although the request

meets some of the guidelines, the X report X. Therefore, X is not medically necessary. Based on the submitted medical records, the requested procedure is not medically necessary. The actual X report has not been submitted for review. The records do reflect that the patient has low back pain with radiation into the bilateral lower extremities a. An initial evaluation by the treating provider on X demonstrated X. A repeat examination on X ironically showed that there was X. Prior peer review indicated that the X report does X. Thus, the X is not medically necessary and non certified

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

Based on the submitted medical records, the requested procedure is not medically necessary. The actual X report has not been submitted for review. The records do reflect that the patient has low back pain X. An initial evaluation by the treating provider on X demonstrated no motor or sensory deficits. A repeat examination on X ironically showed that there was decreased X. Prior peer review indicated that the X report does not confirm X. Thus, the requested X is 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

☐ 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