

Pure Resolutions LLC

An Independent Review Organization

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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:

- 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 is a X who was injured on X. X stated X was at work and went to move a chair and X right X. The diagnosis was pain of right X and right X. An office visit note dated X by X, PA / X, MD was documented. X presented for right X pain initial evaluation. X stated X was at work and went to move a chair and X right X. X reduced it and took X to X, where X had x-rays on X. X walked in a X and stated X pain was improving but X was still with X. Examination showed near-full extension, X, and X / X. The assessment was pain of right X and right X. Nonoperative management for the X was recommended. X would be initiated for X and X. X stated X got a letter stating X was not needed and X reopened the case

to see if it was approved as X did a peer to peer and got an "ok" from Dr. X. X was to continue work restrictions for another X and follow-up in X. A referral to X was provided. Treatment to date included X, X, and X. Per a utilization review adverse determination letter dated X by X, MD, the request for X without contrast, right X, per X order was denied. Rationale: "The Official Disability Guidelines support obtaining an X for X if there is suspected internal derangement. This claimant has had a right X and X are X. There has been no other treatment provided with X which may improve symptoms prior to considering advanced imaging studies. Considering this recent date of injury, X, and X, this request for an X is not supported. Recommend non-certification. "Per a utilization review adverse determination letter dated X, by X, MD, the request for X without contrast, right X, per X order was denied. Rationale: "The Official Disability Guidelines support obtaining an X of the X if there is suspect internal derangement. This claimant has sustained a right X and X. Progress notes dated X states that symptoms are improving. Accordingly, it is unclear why an X is being requested at this time. Furthermore, there has been no participation in any X which may further improve symptoms prior to considering advanced imaging studies. This concern was also stated in the previous review. This request for an X of the right X without contrast is not supported. Recommend noncertification for X without contrast, right X, per X order. "Per a reconsideration review adverse determination letter dated X, by X, DO, the appeal request of X, right X, per X order was denied. Rationale: "Official Disability Guidelines conditionally recommends X and X. Guidelines indicate X for X for X to the X and X, or X pain with X and X or non-localized pain. Progress note dated X indicated the claimant was seen for right X pain with a pain level of X. X exam of right X noted no X, no X upon X, X, X, stable to varus and X testing. Treatments have included X. On X, x-ray of right X noted no X. Records indicate prior denials of the request due to improving symptoms and lack of conservative care, Records do not indicate the medical necessity of the request. Therefore, the appeal request of X, X, per X order, is noncertified. "The requested X is not medically necessary. The medical records document a right X. The medical records do demonstrate improvement in ongoing symptoms. In addition, there is a lack of documentation that appropriate conservative treatment has been rendered. Thus, the previous denial is upheld. X, X, per X order is 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 is not medically necessary. The medical records document a right X. The medical records do demonstrate improvement in ongoing symptoms. In addition, there is a lack of documentation that appropriate conservative treatment has been rendered. Thus, the previous denial is upheld. X, X, per X order 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