Pure Resolutions LLC

Notice of Independent Review Decision

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

IRO REVIEWER REPORT

Date: 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

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. According to the records, the mechanism of injury was described as X. There were no direct office visits available in the records. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X X, X, was denied. Rationale for X, PA/DME: "Per the Official Disability Guidelines surgery for X is recommended. More complex procedures than X repair may be required for lesions involving greater than X of the articular surface, which include X. X is the safest technique and X. Surgery for X is recommended for persistent symptoms following X months of X. Surgical assistant recommended as an option in more complex surgeries. The claimant had ongoing X. There was X. There was a X. There was X. However, there was no documentation of X. Furthermore, the requested procedure was not considered a X. As such, the request for X is not medically necessary." Rationale for X appropriate and medically necessary for this diagnosis and clinical findings: "Per the Official Disability Guidelines X is recommended as an option following open repair of X. The claimant had ongoing right shoulder pain following a X. There was X. There was a X. There was X. However, the claimant was not authorized for a X. As such, the request for X is not medically necessary." Per a reconsideration / utilization review adverse determination letter dated X by X, DO, the request for X was denied. Rationale for X: "Official Disability Guidelines recommends surgery for X. On X, the claimant with right shoulder pain following a X. Exam showed X. No new information was provided that would substantiate

overturning the previous non-certification. As such, the request for X is non-certified." Rationale for X: "Official Disability Guidelines recommends surgery for X. On X, the claimant with right shoulder pain following a X. Exam showed X. Surgery is non-certified. As such, the request for X is non-certified." Based on the medical documentation, there is no documentation of recurrent dislocations. The requested X is an appropriate for the requested X. No 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:

Based on the medical documentation, there is no documentation of X. The requested X is an appropriate for the requested X. No information has been provided which would overturn the previous denials. X are not medically necessary and non certified.

Upheld

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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