Clear Resolutions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 CR
Austin, TX 78731
Phone: (512) 879-6370
Fax: (512) 572-0836
Email: @cri-iro.com

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 is a X who was injured on X. No medical records were documented other than 2 utilization reviews. Per a utilization review adverse determination letter dated X by X, DPM, the request for X was denied. Rationale: "X, the Official Disability Guideline does not recommend it as a treatment option for pain due to a lack of evidence of its benefits. X should only be provided to meet the needs of individuals whose medical needs cannot be met by an FDA-approved drug. Per the submitted documentation, the request is not warranted. The cited guideline does not recommend X. In this case, the claimant presented complaints of pain in the left foot/ankle associated with clinical findings of decreased mobility, decreased sensation, decreased motor strength, limited range of motion, diminished reflexes, and tenderness. They underwent left ankle surgery on X. The claimant was prescribed X. Although the claimant is in their post-operative phase of healing associated with complaints of pain and dysfunction, there was insufficient evidence to support the effectiveness of X. Furthermore, there were no extenuating circumstances documented to warrant a certification. Therefore, the request for X is noncertified. "Per a reconsideration review adverse determination letter dated X, the prospective request for

X was denied by X, MD. The original determination was upheld. Rationale: “This is an appeal to X, which was non-certified by X, DPM, on X. The prior non-certification in X. Furthermore, there were no extenuating circumstances documented to warrant a certification. The provider, X, D.P.M., filed an appeal request with no information provided.” “X, the Official Disability Guidelines do not recommend it as X. X should only be provided to meet the needs of individuals whose medical needs cannot be met by an FDA-approved drug. Upon review of the submitted documentation, it appears that the prior non-certification is appropriate. The cited guideline does not recommend X. Although the claimant presented complaints of pain in the left foot/ankle and in their operative phase of healing, associated with clinical findings of decreased mobility, decreased sensation, decreased motor strength, limited range of motion, diminished reflexes, and tenderness, the request is still not warranted. There was insufficient evidence to support the effectiveness of X. Additionally, there was no indication that the X requested has been demonstrated as significantly safer or more effective than commercially available alternatives. Furthermore, there were no extenuating circumstances documented to warrant a certification. Therefore, the appeal request for X is non-certified. “The requested X is not medically necessary. There is insufficient medical literature to demonstrate its effectiveness over other FDA approved products. No new information has been provided which would overturn the previous denials. 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:

The requested X is not medically necessary. There is insufficient medical literature to demonstrate its effectiveness over other FDA approved products. No new information has been provided which would overturn the previous denials. 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**

☒ **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)**