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

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 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. The mechanism of injury was described as a X. The diagnosis was pain in my left hip. X was seen by X, PA-C on X for left hip, right wrist, and right knee pain. X stated that X was feeling X better. No new symptoms were noted. X stated X at the time due to having WC questions. X was still taking X as needed. The date of symptom onset was X secondary to a X. On examination of the left hip, there was X. The range of motion was full without pain. There was minimal tenderness to palpation over the anterior hip. The assessment included X. X was recommended for the left hip. Per an office visit dated X by X; X-rays of the left hip / pelvis showed hip arthritis. Treatment to date has included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "The request for X is not recommended as medically necessary. There is no information provided regarding X. There are X submitted for review with documentation of progress. There are no significant findings remaining on physical examination. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. "Per a reconsideration review adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: "ODG by MCG Forearm, Wrist, and Hand (Updated: X) Physical / Occupational Therapy for Forearm, Wrist, and Hand Conditions Recommended. ODG Criteria ODG Physical / Occupational Therapy Guidelines: Allow for fading of treatment frequency (from up to X visits or more per week to one or fewer), plus active self-directed home physical therapy. More visits may be necessary when grip strength is a problem, even if the range of motion is improved. The patient is X individual who sustained an injury on X. The patient was diagnosed with pain in the right wrist other specified sprain of the right wrist, pain in the right knee, patellofemoral disorders of the right knee, other low back pain, strain of muscle, fascia, and tendon of the lower back, pain in left hip, psoas tendinitis of left hip, and unilateral primary osteoarthritis of the left hip. In this case, there is evidence that the patient has been previously treated with X. However, the exact number of completed previous X. Additional information is needed to ascertain the necessity of this request. There is no significant evidence provided for review, that would indicate the patient cannot address any current and/or remaining deficits with X. Therefore, medical necessity has not been established. Therefore, the request for X is upheld non-certified. "Based on the submitted medical records, there is no information provided regarding X. There

are X. There are no significant findings remaining on physical examination. 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:

Based on the submitted medical records, there is no information provided regarding X. There are X. There are no significant findings remaining on physical examination. 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

☐ 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