

Clear Resolutions Inc.  
*Notice of Independent Review Decision*

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**Clear Resolutions Inc.**  
**An Independent Review Organization**  
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*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

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adverse determination/adverse determinations should be:

- Overturned (Disagree)
- Partially Overturned (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.

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**INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X**

**PATIENT CLINICAL HISTORY [SUMMARY]:** X is a X who was injured on X. X had a history of X. The diagnosis was spondylosis without myelopathy or radiculopathy of lumbar region, radiculopathy of lumbar region, muscle spasms of back, chronic pain syndrome, and long-term current use of opiate analgesic drug. On X, X, FNP-C / X, MD evaluated X for pain management office visit. X presented for consideration of X chronic pain as a result of degenerative arthritic and postsurgical changes. X stated that the pain did reduce X ability to be physically functional and was often times reduced to sedentary activity at home. X presented for refill of X oral medication stating that the medications were helpful but only to control X pain by taking the edge off of it. X denied any side effects or any major changes to X general health status. X ongoing pain level was X, and worst pain level without medications was X. The percentage of pain relief with medications was X. On examination, X had irregular gait. Sensation was X. Reflexes were X. Motor strength testing revealed X. Lumbar, lumbosacral spine and sacroiliac spine examination revealed X. There was slight drop foot on the left. A X was ordered. On X, X, FNP-C / X, MD evaluated X for pain management office visit. X had left shoulder, left elbow, low back sprain, lumbar radiculopathy, and cervical radiculopathy. X chief complaint was lumbar, neck, and left shoulder pain. After the

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### *Notice of Independent Review Decision*

---

injury, X complained of cervical, elbow and shoulder pain. X also had left neck tingling and pain into the thumb and finger, worsening late and into the left shoulder. X presented for consideration of X chronic pain as a result of degenerative arthritic and postsurgical changes. X presented for refill of X oral medication stating that the medications were helpful. X denied any side effects or any major changes to X general health status. X ongoing pain level was X, and worst pain level without medications was X. The percentage of pain relief with medications was X. X prior treatment included X. On examination, X had irregular gait. Sensation was diminished at X. Reflexes were X. Motor strength testing revealed X. There was slight drop foot on the left. A X was ordered in the last month which was pending completion. A urine drug screen was X. An MRI of lumbar spine dated X revealed X. Endplate edema at X was improved. However, there was some residual endplate edema, and also some enhancement of the end plate and disc space. A normal CBC and normal inflammatory markers might be reassuring that this was not X. At X, there were X. At X, the disc space was X. Portions of the disc, however, were bright in signal on X. There was some enhancement of the margins of the disc, and also minimal enhancement of the right upper end plate of X. The endplate edema noted previously was improved. This was one of those cases where it was very difficult to differentiate X findings from X. If this was X, there had probably been improvement. At X, the disc was X. Broad-based X were noted.

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There was right lateral recess narrowing. There was right greater than left foraminal narrowing which was unchanged. There were signal abnormalities in both kidneys, probably cysts.

Diverticulosis was noted in the sigmoid colon. Per an undated Letter of Medical Necessity, X, MD documented the medical necessity for the X. Based on X clinical presentation and history, the use of X was deemed medically necessary for the following reasons. For unresolved chronic pain, despite X diligent efforts and multiple conservative treatments, their chronic lower back strain had persisted and significantly impaired their daily life. For non-response to medications, X suboptimal response to pain medications underscored the need for alternative treatments, as long-term medication use carries risks and limitations. For established efficacy of X is a well-established and evidence-based treatment modality for chronic pain conditions, including chronic lower back pain. Numerous clinical studies and patient success stories supported its effectiveness. The X would offer the potential to significantly reduce pain, improve functional capacity, and enhance the overall quality of life for patients suffering from chronic pain conditions. Based on X medical history and the chronic, unrelenting nature of the pain, a X was medically necessary. Dr. X respectfully requested to provide authorization for this treatment to help X achieve better pain management and an improved quality of life. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "ODG

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by mcg Last review/update date: X, X Treatment type: X; may be a first-line or second-line option. A peer discussion occurred, and the case details were discussed. The records provided do not include a favorable psychological evaluation. The peer stated that additional records would be submitted at a later time. Based on the information available for review, the request is not shown to be supported by the ODG nor otherwise medically necessary. As such, the requested X is non-authorized. "Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Per ODG, "X may be indicated when ALL of the following are present X" In this case, there is a history of prior X. However, the records briefly mention a X on X. The records do not note any details regarding this trial, including any benefits or complications, or why the X would need to be repeated. Also, there is no record of psychological clearance. The request is not shown to be medically necessary. Therefore, the requested X is non-certified. "Thoroughly reviewed provided records including provider notes, imaging results, and peer reviews. Patient has had multiple treatments for their pain including but not limited to X. Given continued pain despite these prior treatments, consideration for a X is warranted. The provider's documentation also meets the cited ODG criteria. X is medically necessary and certified

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

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**SUPPORT THE DECISION:**

Thoroughly reviewed provided records including provider notes, imaging results, and peer reviews. Patient has had multiple treatments for their pain including but not limited to X. Given continued pain despite these prior treatments, consideration for a X is warranted. The provider's documentation also meets the cited ODG criteria. X is medically necessary and certified  
Overturned

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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
- 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

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- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**