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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 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. X, briefly losing consciousness. The diagnoses were

accidental fall with closed head injury and bilateral upper extremity weakness, prediabetes, chronic lower back pain, nicotine dependence, and morbid obesity.

"No office visits available."

The treatment to date consisted of X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "In this case, according to 000 guidelines. Although X recently X, the documentation docs not show objective functional deficits, confirm a homebound status, or include an in-home assessment There is also no clear reason X cannot attend X unjustified at this time. Therefore, X is not medically necessary."

Per a reconsideration review adverse determination letter dated x, the appeal request for X was non-certified by X, MD. Rationale: "ODG by MCG (Last review/update date: x) "X: X." The submitted documentation does not show objective x. In keeping Official Disability Guidelines (ODG) guidelines, insufficient clinical information was furnished to establish medical necessity. Therefore, the request for X upheld and non-certified

Thoroughly reviewed provided records.

The patient can likely benefit from further X. However, there were no records provided to substantiate requests for X. It is unclear if the patient remains with major functional deficits, or other reason why would not be able to attend X. Thus, X request does not appear necessary. 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:

Thoroughly reviewed provided records.

The patient can likely benefit from X. However, there were no records provided to substantiate requests for X. It is unclear if the patient remains with major

functional deficits, or other reason why would not be able to X. Thus, X request does not appear necessary. 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:

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- TMF SCREENING CRITERIA MANUAL
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- MILLIMAN CARE GUIDELINES
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- INTERQUAL CRITERIA
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE