Applied Resolutions LLC
An Independent Review Organization
900 N. Walnut Creek Suite 100 PMB 290
Mansfield, TX 76063
Phone: (817) 405-3524
Fax: (888) 567-5355
Email: justin@appliedresolutionstx.com

Date: 11/5/2018 and amended 11/6/2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX/XX XX XX extremities

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Neurology

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

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX. XXXX. XXXX was diagnosed with post-XX syndrome, unspecified injury of the XX, XX, XX, XX, XX of the XX, and XX of the XX region. XXXX for traumatic XX injury. XXXX. XXXX was XX for an unknown time, XXXX. XXXX had been seen at XXXX, where a XX was normal. XXXX had been diagnosed with a XX and discharged. XXXX complained of XX, XX XX in the XX XX, and XX XX and XX extremity XX and XX, XX more than the XX. XXXX had XX, XX sensitivity, and balance difficulty. XXXX reported XX episodes of XX, which lasted for XX to XX days. XXXX was taking XXXX at the time. XXXX complained of episodes of XX. Examination revealed a XX of XXXX. XX revealed no XX, XX, or XX. XX. Neurological evaluation revealed a motor strength of XX/5 XX; normal XX XX extremities and XX extremities to light touch, XX, and temperature; XX XX reflexes; and gait and station within normal limits. The rest of the examination was also within XX limits. On XXXX, XXXX returned to XXXX for a follow-up. XXXX reported that XXXX XX had improved slightly in intensity. XXXX complained of seeing XX at night XX XX, which had caused XXXX to discontinue. XXXX XX due to XX XX. The examination was unchanged from prior. A XX XX XX dated XXXX revealed XX-XX complexes at each XX level in conjunction with XX XX XX XX and mild XX XX from XX-XX through XX-XX, worse at XX-XX. There was XX XX XX at XX-XX, XX-XX, and XX-XX; mild-to-moderate XX XX XX at XX-XX and XX-XX; and XX XX at the XX superior XX XX. An XX of the XX XX dated XXXX, showed a tiny XX-XX central XX XX with XX XX superimposed on mild XX-XX complex with XX XX XX and XX XX, XX worse

than the XX. There were XX-XX, XX-XX, and XX-XX XX-XX complexes causing mild XX XX and XX XX XX; mild XX-XX XX XX and borderline XX XX without XX XX; XX XX central XX; and straightened XX. An XX of the XX dated XXXX showed no acute XX abnormality. Mild XX and XX XX disease was also noted. An XX dated XXXX was abnormal with nonspecific XX-XX abnormality. The treatment to date included medications (XXXX).

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

Per ODG: XX. There is no evidence in this case of XX system dysfunction (i.e., XX, XX, and nerves, XX, or muscles.) XX/XX testing is not medically necessary for this claimant's condition. Per ODG: "XX (XX) is a well-established diagnostic procedure that monitors XX XX activity using XX XX and provocative maneuvers such as XX and XX XX. Information generated includes alterations in XX XX activity such as XX changes (nonspecific) or XX (XX). XXX is not generally indicated in the immediate period of emergency response, evaluation, and treatment. Following initial assessment and stabilization, the individual's course should be monitored."

There is no evidence in this case of known or suspected XX, focal XX pathology, or persistent abnormal states of consciousness. Therefore, the XX/XX XX XX extremities is not medically necessary, and the decision is upheld for this claimant's condition.

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 XX 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

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

Per ODG: "Indications for XX and Nerve Conduction Studies in the TBI patient: