Applied Assessments LLC
An Independent Review Organization
900 Walnut Creek Suite 100, #277
Mansfield, TX 76063
Phone: (512) 333-2366
Fax: (888) 402-4676
Email: admin@appliedassessmentstx.com

PATIENT CLINICAL HISTORY [SUMMARY]: X with date of injury X. X was diagnosed with a X. X visited X, DO on X for a follow-up. X continued to have moderate-to-severe X felt that the pain had escalated over the prior month or so. X was seen X. X stated that it was the worst and rather than raising X, X wanted to finally go ahead with the X procedure to help reduce X pain, inflammation, and improve X overall affect and quality of life. The combination of X medications X had helped X; however, over the prior two months, X felt having X pain, which was X in nature. Examination showed moderate tenderness to palpation of the X. X had failed X options consistent with the Texas Labor Code. X wanted to go ahead with the X whereby X was allowed for up to two procedures in a given year for recurrent X. On examination, X showed classic signs of X including positive X test, decreased X, and pain radiating X. The plan included X as indicated to help hasten in reducing the pain, improving X outlook affect, and decreasing X medication. X presented with X associated with X and wished to be sedated or "knocked out." On X, X complained of moderate-to-severe X pain. Dr. X indicated that the peer review physician had not looked at the X that X had undergone prior to visiting X. X pain was rated X. Over a year prior, X had excellent relief after utilizing the X. X was under the Official Disability Guidelines for X as evidenced by a positive X sign, moderate X, decreased X to receive treatment, which either X or relieved the naturally X state. As a result, the healthcare cost needed to be increased along with another visit to see that X got X treatment. X had failed X rehabilitative care. X was requiring ongoing X. X oral medications were refilled. X was taking X medications compliantly. X intake urinalysis was negative for X use. X

“X” showed good pain-coping mechanism X and X generalized X disorder-X score was fine with the combination of X in the morning and X at night, which were providing both X inhibition. X was using x in conjunction with X on a steady basis. X wanted to get off these medications. The X was an excellent avenue for X to consider the treatment model. X had received a functional improvement and decreased pain with more than X decreased use of medications in the past. Due to X associated with X, X would require an X for the painful procedure. Per the note dated X by Dr. X, X was taking medications compliantly for X ongoing X pain. X care was recommended; however, X continued to have further X associated with X. As a result, Dr. X was left with the option of oral medication management, which included a combination of a X as a co-X, X at night, and X in the morning. These medications allowed X to function. X did help X children and had part-time work. X score was X showing mild reactive X and X generalized X -X score was X. X intake urinalysis was consistent with the agents. There was no evidence of X. Good compliance had been noted. X was seen walking with an X. X had moderate tenderness to palpation of the X region. X was discussed, which would be considered in the future. A X myelogram dated X demonstrated findings of status post anterior X with X level. The X appeared well positioned. There was minimal X. There was no obvious evidence of X. There was X filling of the X, although that was not obviously X. The remaining X filled normally. A post-myelogram CT scan of the X revealed X. There had been prior X, which were in good alignment and appeared to be well incorporated into the X. There was some soft tissue along the X; however, there was no X effect on the X. The X. The X appeared to be just minimally more posteriorly located within the X, although there was no X. No X was evident. The X levels were within normal limits. The treatment to date included medications (X), X. Per a Utilization Review Determination Letter dated X by X, MD, the prospective request for X between X between X and X was non-certified. Regarding a X, “the Official Disability Guidelines state that X is recommended as a possible short-term treatment of X pain. The guidelines also state that X have shown to be more effective and faster treatment than X. X should be used in conjunction with active rehab efforts. X is not recommended for X pain. The purpose of X is to reduce pain and inflammation. There are certain criteria for X, for example X due to X must be documented through objective findings and imaging studies. Failed attempts of X treatments, X should be performed with X, and a maximum of X should be performed. Repeat X are not recommended unless there is documentation of improvement and function.” The

letter also documented that “the requested X may be appropriate at this time. Although the claimant suffered from X pain with previous excellent benefit from a X, a separate request within this review was non-certified. For this reason alone, the request for X is non-certified. Regarding X, the Official Disability Guidelines state that there is no evidence for X during an X, although it does state that there are some potential diagnostic and safety issues with X. One concern with X is the inability of the claimant to experience the expected pain and X associated with X. The requested X is not supported at this time. The evidence-based guidelines state that there is no evidence for X, although it does state that there are some potential diagnostic and safety issues with X. One concern with X is the inability of the claimant to experience the expected pain and X associated with X. Although the claimant reported X related to X, the use of X during this procedure is not supported. For this reason, the request for X is non-certified.”

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

Based on the clinical information provided, the request for X between X is not recommended as medically necessary, and the previous denials are upheld. Per a Utilization Review Determination Letter dated X by X, MD, the prospective request for X was non-certified. Regarding a X, “the Official Disability Guidelines state that X is recommended as a possible short-term treatment of X pain. The guidelines also state that X have shown to be more effective and faster treatment than X. X should be used in conjunction with active rehab efforts. X is not recommended for X pain. The purpose of X is to reduce pain and inflammation. There are certain criteria for X, for example X due to X must be documented through objective findings and imaging studies. Failed attempts of X treatments, X should be performed with X, and a maximum of X should be performed. X are not recommended unless there is documentation of improvement and function.” The letter also documented that “the requested X may be appropriate at this time. Although the claimant suffered from X pain with previous excellent benefit from a X, a separate request within this review was non-certified. For this reason alone, the request for X is non-certified. Regarding X, the Official Disability Guidelines state that there is no evidence for sedation during an X, although it does state that there are some potential diagnostic and safety issues with X. One concern with X is the inability of the claimant to experience the expected pain and X associated with X. The requested X is not

supported at this time. The evidence-based guidelines state that there is no evidence for X, although it does state that there are some potential diagnostic and safety issues with X. One concern with X is the inability of the claimant to experience the expected pain and X associated with X. Although the claimant reported X, the use of X during this procedure is not supported. For this reason, the request for X is non-certified." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The Official Disability Guidelines require documentation of X on physical examination corroborated by imaging studies and/or electrodiagnostic results. There are no recent imaging studies/electrodiagnostic results submitted for review. There is no documentation of any recent active treatment. The patient's objective functional response to prior X is not documented to establish efficacy of treatment.

Given the documentation available, the requested service(s) are upheld and not medically necessary in accordance with current evidence-based guidelines.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES