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

PATIENT CLINICAL HISTORY [SUMMARY]: X with date of injury X. X was diagnosed with other X, X was evaluated by X, MD for the. The X pain was X. The pain was rated as X. X had more pain with X. The examination showed an X. X test was positive. X at the X was noted. X of the X and X consistent with X was noted. The X showed extension X. An MRI of the X dated X showed a X. Treatment to date consisted of medications (X), X. Per a utilization review determination letter dated X by X, MD, the request for X, was denied. It was determined that understanding the date of injury, the enhanced imaging protocol completed, and the clinical assessment presented, the request for X, was not supported. Although Official Disability Guidelines offers recommendation for X, the recommendation primarily discusses X. According to the documentation, X had a X of injury X months prior. The most recent examination noted X. An MRI showed a X likely representing a X. There was no official radiologist's MRI report seen in the files There had been treatment with X. X was ordered on X and it was not clear if X was taking the X. Although there were complaints of X pain noted, it was also not described where X complained of X pain. Additionally, the provider noted X however, did not indicate whether there was X. As such, when taking those factors into consideration, there was insufficient clinical documentation presented to support the request. Therefore, the request for X, X, MD and X was not medically necessary. A letter dated X by X, MD indicated that the reconsideration request was non-certified. Rationale: “The Official Disability Guidelines recommends X when there is evidence of X. The ODG recommends a X as an option in more X. The provided documentation indicates there is X pain X

months out from injury with associated X. The symptoms persist despite treatment with X. There are physical examination findings of X, X of the X, positive X test, and X. A X revealed a X soft tissue of the X of the X to the X likely representing a X. There is no evidence of an X process. Based on the provided documentation and ODG recommendation, the reconsideration request for X is not medically necessary".

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

The ODG supports X when there is evidence of X. A X is an option for more complex X. The documentation provided indicates that the injured worker has persistent X pain following an injury on X. The injured worker complains of X. Previous treatment has included X. A physical examination documented X. A X MRI documented a likely X. There was no documentation of X. The treating provider has recommended an X. Based on the documentation provided, the ODG would not support the requested X as there is no documentation indicate that there is X present and it is unclear if the current symptoms related to the X as the injured worker has persistent X consistent with a possible X.

Given the documentation available, the requested service(s) is considered not medically necessary and the request is 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