**Applied Resolutions LLC**
**An Independent Review Organization**
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**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:

X

**PATIENT CLINICAL HISTORY [SUMMARY]:**
X who sustained an injury X. X was X. X was evaluated by X, MD on X for an X. X noted that X. X had X. The X. If X. There was X. Dr. X recommended X. Per a X that it was X. It was also X. This X. X was a X. In addition to X. X was also X. Because X. This X. The patient's X. The need to have X. X was a X. X and X. Based on the X and X. The treatment to date X. Per a utilization review decision letter dated X was denied by X MD. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, this request is non-certified. Based on the clinical information provided, the claimant X. There are X. X and needs of the patient, additional information would be needed in X requested. Therefore, this reviewer would not recommend certification for the request." X wrote an appeal letter on X. X discussed the difficulties with X which was X. X reported X. X had X. X must X. X also X. The X. X attention was X. A X was recommended. This X had clinically demonstrated X. X would be provided to X. X would X. X also met the X. Per an X denial was upheld by X, MD. Rationale: "Per evidence-based guidelines, X. In this case, an appeal for

X. Given the presented X. Guidelines stated that prior authorization should be X.

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

X with X. Per a utilization review decision letter X. Said information was provided in an X. The X. While some of these X. Agree that these X. Particularly, how often does the X

The previous determination is overturned. The patient demonstrated a lifestyle that requires this X. Given the documentation available, the requested service(s) is considered medically necessary.

**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