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## **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:

X

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

X who sustained an injury on X while X was X. X and X on X. The diagnoses included X. X was seen by X, MD on X for X. The pain was X. It was rated X. X was able to X. It was noted that X had X. The duration of relief was X. X had excellent X. X was able to X. X were not noted. X was having X and would like X. On X and X. The X was X. An MRI of the X showed X. Treatment to date included medications X. Per an adverse determination by X, MD on X, the request for X with X was non-certified. X: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is

non-certified. X clinical findings should be clearly addressed to establish a clear comparison and validate its efficacy from the prior procedure. There were no X documented in the medicals dated X to objective validate significant X.” Per an adverse determination by X, MD on X, the request for X with X was non-certified. X: “Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is not medically necessary. In light of this presenting issues and in the absence of pertinent X that would require X with X is not medically necessary as documentation of X which includes a X program was not established.”

**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: X as medically necessary, and the previous denials are upheld. Per an adverse determination by X, MD on X, the request for X with X was non-certified. X “Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. X clinical findings should be clearly addressed to establish a clear comparison and validate its efficacy from the prior procedure. There were no objective quantifiable measurements documented in the medicals dated X to objective validate significant X.” Per an adverse determination by X, MD on X, the request for X was non-certified. X: “Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is not medically necessary. In light of this presenting issues and in the absence of X circumstances that would require deviation from the guidelines, the APPEAL for X is not medically necessary as documentation of active X was not established. An X is not a stand-alone procedure. Moreover, X findings such as X cannot be established in the recent medical report to indicate serious underlying conditions to justify the need for the request. Lastly, the guideline states that X is X. One of the side effects of X includes an increase in X. Pertinent X circumstances that would require X from the guidelines were not noted as well. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient underwent X. Although there are subjective reports of improvement following prior X, there are no objective

measures of improvement documented to establish efficacy of treatment.

Therefore, medical necessity is not established in accordance with current evidence-based guidelines 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