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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 with date of injury X. X was X. X did X. On X was evaluated by X, MD for complaints of X. X had X. Diagnostic X was recommended as X was X. On X, Dr. X again requested X. This had been denied. On X was evaluated by Dr. X for X. X had been denied X and continued to have X. On examination, X. X was X. The assessment was X. An MRI of the X and X. At X there was X. There was also X. At the X, there was X noted. A X. There was also X. There was X. At X, there was X. Treatment to date included X. Per a Peer Review dated X, MD, the request for X was non-certified. The rationale for denial was as follows: "ODG X Recommended as a X. This treatment should be administered in conjunction with X. Not recommended for treatment of X. there are X. X are not recommended as a X. X are not recommended. See X. The claimant sustained an injury on X. The mechanism of the injury from being X. The claimant was diagnosed with X. Report dated X claimant indicates X. No objective findings noted. Request is for X. There

is X. Based on the fact the condition is X and has X. However, based on the fact that according to the Guideline, X is not medically necessary.” Per a Peer Review dated X, MD, the request for X was non-certified. The rationale for the denial was as follows: “Per Official Disability Guidelines, X. X must be X. A request for the X. In this case. the claimant has X. The MRI shows X. However, there were X. Therefore, the request is not medically necessary and is not certified.”

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

The claimant had been followed for X. The claimant had X. The claimant’s evaluation on X. There was X. The claimant did have a X. Based on the clinical X. Therefore, it is this reviewer’s opinion that medical necessity is established, and the prior denials are overturned.

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