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

Notice of Independent Review Decision

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who was injured on X. X worked as a X and was X when X. This resulted in X. Since then, X had X. X history was significant for X in X with X. The diagnosis was X. Per the office visit noted dated X by X, MD, X was X after X. X had been X. X had X. X did X, which X stated X. X believed X. X required X, and X. X had noted X. X examination revealed X. The X was X. There was X. The X was X. The X was X. The X revealed X. X was X. X testing was X. X was X. X was X. X were X. X were X. There was no X. X was X. The assessment was X. X believed X was X and requested that X. X planned to refer X for X. Regarding activity, X may be X. X may X, X may X. X

was to X. Dr. X recommended to continue X. Per an office visit note dated X, X obtained of X on X, revealed X. There was X. There was X. No X were X. X of the X on X revealed X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was noncertified by X, MD as not medically necessary. Rationale: "The medical treatment guidelines support X. In that the claimant has X, the X exceeds guideline recommendations. As so, this request cannot be supported. Therefore, X is not medically necessary." Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD as not medically necessary. Rationale: "In this case, the claimant was noted to have X with X. The claimant continues to X. However, the claimant was also noted to have X. Therefore, the appeal request for X is not medically necessary."

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 is not recommended as medically necessary, and the previous denials are upheld. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient underwent X on X. The patient has X. The request for X would exceed guideline recommendations. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of X. Note dated X indicates that X believes X. X requires no X and has no X and there is no X. X is X. The X is X with X. X is X. X is X. The patient has completed X and should be X with X.

Given the documentation available, the requested service(s) is considered not 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

☐ TMF SCREENING CRITERIA MANUAL