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 was X when X. X, X and X. X was X. Since that time, X had X. The diagnosis was X. On X, X, DO evaluated X for continued X complaints, which had been corroborated with X, which was consistent with X. Dr. X documented that a doctor misinterpreted the ODG guidelines and the fact that X did not have to have X on an X. X was more common than X; it was X. It was

causing X, which X continued to X as to why X had X. That was not a reason to deny care because they could not see a picture that showed X not mandated under the ODG guidelines. The ODG guidelines specifically stated X was an indication for X, which had been time proven clinically in X under the specific care and X. As a result, they were going to have to resubmit for it. Furthermore, the doctor referred to X. They were only asking for X that was a combination of X and X as indicated to keep X, X for the procedure to X of X. The national averages were anywhere from X for X causing X, but due to the fact that they X, and X was not X and X, they had X, that was X in X procedures. The X and X were X. Due to the X, they were using X. At the time, X was X with X and X. X pain score was X. X had X. They were trying to X, X with X and were going to arrange for X. Any further delays would lead to X with X. An X of the X dated X showed a X. A X was seen X that was X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, DO. Rationale: “Per ODG X guidelines regarding criteria for X, "X must be well documented, along with objective X on X. X must be corroborated by imaging studies and when appropriate, X, unless X, X, and X support a X diagnosis. A request for the procedure in a patient with X requires additional documentation of X associated with X." In this case, there is no documented evidence of X or X. X revealed X. Furthermore, there is no record of extraordinary circumstances that would necessitate X for this procedure. X is not recommended and there is X that would indicate X as to require the involvement of X or X. Therefore, the request for X, X, is not medically necessary.” Per a reconsideration review adverse determination letter dated X, the request for reconsideration for X, as X was noncertified by X MD. Rationale: “Based on the clinical information provided, the Reconsideration for X as X is not recommended as medically necessary. The initial request was non-certified noting that, 'In this case, there is no documented evidence of X. X MRI revealed X. Furthermore, there is no record of X that would necessitate X for this procedure. X is not recommended and there is no record of factors that would indicate X as to require the involvement of X or X. Therefore, the request for X, is not medically necessary." There is insufficient information to support a change in determination, and the previous non-certification is upheld. There is no significant X at the X on MRI. There is no X, X or X. Therefore, medical necessity is not established in accordance with current evidence based guidelines.”

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

The request for X, as 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-certification is upheld. There is no X. There is no X, X or X. Therefore, medical necessity is not established in accordance with current evidence based guidelines." Recommend upholding the previous denials. The submitted X MRI notes that there is no X, X or X. A X is possible and X but X. There is no X documented.

Medical necessity is not established.

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