

**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: X@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, 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 X on X when X. X was X. X was X. At the same time, X was X, a X. The X apparently resulted in a "X" X. There was X. X noted that the X to the X caused X to X and X, X. X noted that, at the instance X was X by the X, X and X "X" X. X injured X. The diagnosis was X. X, DO evaluated X on X for continued X as a direct result of X on X. X had been denied. Dr. X wrote that X was an indication for X as practiced. X had X due to X and was indicated for X. Furthermore, the reviewer denied care because of "X," and no one was asking for X. Dr. X wrote that this was a X that did however, due to its X require X in the X that was a combination of X and X with X of the X for a X in the X. This was an advanced procedure that was X for X who were practicing this specialty. Furthermore, the X

supports X, which X or X the X. This was a X with X including X with X. The most prudent course of action, other X under the X guidelines and was practiced in the X for X was X, which had helped X of X of patients avoid X, X, X and X as X wanted to get back to X as X requiring X. Once again, X had marked X. X had X with X. As a result of the denial, X was requiring X such as X to X, and a X at X. They would resubmit for X once again. An X of the X dated X showed the following findings: X. X. X. There was X within X and X within X. No X was present, and the X appeared to be due to X. Treatment to date included X (X, X) X. Per a peer review by X, MD and a utilization review adverse determination letter dated X, the request for X at the X - due to X will require a X utilizing a X to X, X at X and X with X performed under X was denied as not medically necessary. Rationale: "In this case, as noted on prior review, X revealed X with no evidence of X. Furthermore, as also noted on prior review, there is no record of extraordinary circumstances that would necessitate X care for this procedure. X is not recommended and there is no record of factors that would indicate such X as to require the involvement of an X or X. The request is not shown to be medically indicated. Therefore, the requested X due to X will require a X utilizing a X to X, X and X performed under X is non-certified." Per a peer review by X, MD dated X and a utilization review adverse determination letter dated X, the prior denial was upheld. Rationale: "Per this review, there is a request for X. Objective evidence of recent symptoms X, associated with X of X was not identified. Overall, this request for X due to X will require a X utilizing X to instill X, X at X and X with X performed under X is not shown to be medically necessary and is non-certified."

**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 at the X due to X will require a X utilizing X to instill X, X at X and X with X performed under 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 X. There is no significant X documented on X. There is no documentation of recent or ongoing X. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

**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