

Applied Resolutions LLC
An Independent Review Organization
900 N. Walnut Creek Suite 100 PMB 290
Mansfield, TX 76063
Phone: (817) 405-3524
Fax: (888) 567-5355
Email: @appliedresolutionstx.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, when X. The diagnosis was X. X was seen by X, MD on X for X. X was X in X, with X. X rated X. X had X since X last visit and X. X described X as X. The position that made X was X. X noticed some X. Examination findings included X and X (X with X and X and X). X was noted X. X was X on the X, X to X / X were X and to X / X were X. There was X in X or X present and X. X was X. The assessment included X. X of X was recommended. X of X was ordered. An X dated X showed X of the X without X or X. Treatment to date included X. Per a utilization review adverse determination letter / peer review dated X by X, MD, the request for X was denied. The rationale, "Conditionally recommended as a X (defined as X in X) with corroborative findings of X. This treatment should be administered in X with X, including X (or X) and/or a X. Not recommended for treatment of X resulting in X unless there are X findings on examination. X are not

recommended as a treatment for X or for X. X at X are not recommended. The request is NOT certified because the following criteria were not satisfied: there was no objective evidence that the patient was X to conservative treatment such as X; X fails to corroborates the presence of a X; the request does NOT include X. In the peer-to-peer discussion, the requirements of the Guides were reviewed with the provider (or designee). The deficiencies in the request were discussed, and the reasons for non-certification were given. Since a successful peer-to peer conversation has taken place, no additional clinical information is expected to be provided.” Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the request for X was non-certified. The rationale, “Per evidence-based guidelines, X (X) are recommended as a short-term treatment for X. In this case, the patient presented with X in X, with X at X. X was X and X. X revealed X was X on the X. The X was X, X was X, X was X, and X was X. X exam showed evidence of X in the X or X, X was X. There was X. The X were X. In addition, X. An appeal request for X at X and X and X was made. However, the presented findings were insufficient to support the request for X. On exam, X was intact for X and there was no quantifiable measures of X documented. Per guidelines, X must be well documented, along with objective X findings on X examination. Furthermore, objective evidence of X from all indicated X could not be identified as prior X notes were not submitted for review. Lastly, X is not a stand-alone procedure. There should be evidence of X in association with X. There were no additional medical reports submitted to overturn the previous denial of the request.”

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

The Official Disability Guidelines discusses X. An X may be indicated in situations where symptoms, examination findings, and diagnostic studies correlate to confirm a X at a particular level. Such findings are not present at this time. It appears this claimant may have X or X. Again, it is not clear that the claimant has a X either on examination or by X or by symptoms. A rationale for X in this setting is not apparent.

The request for X is not supported as 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