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. The mechanism of injury was detailed as X was diagnosed with X. X included X and X / X. The following records were taken from the utilization review due to lack of direct medical records. An MRI of the X dated X a X and X. X had X and X with the X also X. Additional findings included X and X to date included X, X, X, X / X, and X. Per a utilization review adverse determination letter dated X by X, DO the request for X, X and X, X was denied. A X dated X noted that X was not at X. X was most recently seen on X complaining of X. X pain X and was X, X, and X. Nothing made X pain X and it had been ongoing for X. On X, X had X and X. X had a X between X and X. The treatment plan included X and X. Rationale: The clinical basis for denying these services or treatment. According to the Official Disability Guidelines, the request for

diagnostic X is not supported while the document dated X, noted that X had X and X with X and a X and X. There was X for X to X. The X to specify that the X. The examination conducted on X, did not include X, a X. The physician failed to specify the X nor what X to. Additionally, X had noted X on MRI. Lastly, this procedure was primarily performed prior to a X and was X. The physician would need to X on the medical necessity of the X as there was X would be based on the rest of the X. As such, the request for X, X; and X on the X, X was non-certified. Per a reconsideration review adverse determination letter dated X, the appeal for the request for X, X and X on the X, X was denied by X, MD. Rationale: "The Official Disability Guidelines states that X are recommended on a case -case basis for clients with X when the diagnosis X after standard evaluation using a clinical / X, X and X. X is not generally recommended. When required for X, the patient should remain X. The previous requests were denied as there was X for the patient to X at the X. The provider failed to specify that the X remaining X after a standard evaluation using insufficient to support evidence of X. In this case, the patient had complaints of X. While it was reported that the patient had a X and X, the X were X. The most recent clinical exam findings were insufficient to support evidence of X / X. In addition, the documentation identified that the patient had a previous X. It is unclear why the patient would require a X at the X. The documentation did not clearly identity that the patient needed to be evaluated for a X when X and X. X was provided as to why X was being recommended. Therefore the medical necessity of the treatment has not been established. As such the appeal of denial for X and a X is recommended 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 and 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. There are X findings documented on X. There is no documentation of a X in a X or X. There is X information provided regarding prior 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