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**An Independent Review Organization**  
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**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 sustained an injury on X when X. X was diagnosed with X. X was seen by X from X through X. On X, X presented for X. There was X. On X, X continued to X. X continued to have X. On X, X continued to report X. There was X. An MRI revealed X. A X dated X showed X. Treatment to date included X. X had X. Per a Utilization Review decision letter dated X, the request for X was denied by X. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, X is recommended on a case-by-case basis as X. In this case, the patient X. X had X. A request was made for X. However, there were no comprehensive clinical exam findings in X, to include X.

Also, X is not generally recommended. Lastly, it is not clear if this is to be X". Per an Adverse Determination letter dated X, the prior denial was upheld by X, MD. Rationale: "Per evidence-based guidelines, X is recommended on a case-by-case basis as X for X. In this case, the patient continued to complain of X. X continued with X. Due to X, X would require the X. This was not X. Furthermore, X. A request was made for APPEAL X, X. However, there was still no comprehensive clinical examination in X associated specifically to X. In addition, the medical records submitted were limited as it did not demonstrate X. Moreover, there was no documentation in the patient's treatment plan that X. All patients should be informed of the X. Furthermore, X is not recommended when X. A most recent or an updated office visit with X should be addressed. Clarification is needed for the request at this time and how it might change the treatment recommendations as well as the patient's clinical outcomes. X were not identified".

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

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 submitted X dated X notes at the X there is X. There is no significant X documented at X. The Official Disability Guidelines note that there is no evidence that X. There should be evidence of X with X. This can include X.

There is no documentation of X. Recommend non-certification.

**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