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. The mechanism of injury was noted as X. The diagnoses included X. On X, X was seen by X, DO for continued complaints of X. X reported X, X and X the X. The pain X. The X examination noted X. X was X. X was noted X the X. The X test was X on the X. The assessment included X and X without X. The treatment plan called for X. An X of the X dated X revealed a X. X and X; and X could be further evaluated using a X if indicated. Treatment to date included X. Per a Peer-to-Peer Call dated X, the request for X was denied by X, MD. Rationale: "The Official Disability Guidelines recommend X for claimants with X after X. The claimant was evaluated for continued X. The X examination noted X.

However, the claimant also reported that X. Additionally, the X confirmed a X. Given the evidence of X, the request for X is not medically necessary." Per Reconsideration Review dated X, the request for X between X and X was not non-certified by X, MD. Rationale: "Per ODG, "Criteria for X to determine X: Clinical presentation should be consistent with X referenced above. X involves X. (1X. In this case, pain X in a X to the X and is accompanied by X. There are no documented X to support an exception to the guidelines. X are not shown to be medically necessary."

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 is not recommended as medically necessary and the previous denials are upheld. Per a Peer-to-Peer Call dated X, the request for X was denied by X, MD. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The submitted clinical records indicate that the patient reports X. Office visit note dated X indicates that the patient's X. There is X. Current evidence based guidelines require an 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