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

Amended Letter

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 Medicine

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 X. X was X and X and X and X, and the X and X, X and X. The diagnoses included X / X and X / X. X was seen by X, MD on X for a follow-up on X. X reported X. X rated X pain X. X was only able to do X to X of X. X was X at the time. X had been in X and X. X also X. X had X and was X to X. The X was X. X was X from the X. It showed X, X. X, X, and X were all X. On X, X reported X. The X was described as X, X and X, X, and X, and was X. X was able to do about X to X of X. X had X on the X to the X. X reported X, X, and X were not helping with X. The pain was X with X. On examination, there was X on the X. X had pain on X. X, X on the X. The X was X. On X, X presented for a follow-up of X. X stated X continued to have X, X, X, and X. X rated X pain X. X was only able to do X of X. X was X from

the X. An X of the X on X showed X with X of the X. An X of the X on X demonstrated X and a X and X; X, X, X due to X from the X; X. There was no X or X. X / X on X showed X and X on the X. Treatment to date included X, X, and X and X. Per a peer review by X, MD and a utilization review dated X, the request for X, X was non-certified. Rationale: "Per ODG, 'Recommended prior to considering X. Not recommended in the X. A diagnostic X is the preferred procedure to determine X. No more than X should be performed X. X are not recommended. ODG Criteria, "Criteria for Diagnostic X to determine X should be consistent with X, X and X. X involves X to a specific X, and it is only recommended as a X, not X, X. X is not recommended for the X. (1) X, X, previous X, X. X, X, or X." In this case, X revealed X. The X is X. Per Dr. X on X, the pain was X and X. There are no documented X to support an exception to the guidelines. X are not shown to be medically necessary and is noncertified." Per peer review by X, MD on X and a utilization review dated X, the request for X, X was non-certified. Rationale: "As noted in ODG's X and X Criteria for Diagnostic X, one of the primary criteria for x or such X that a claimant does not have X. Here, the claimant has X, X which have been X. Obtaining X are not indicated or appropriate in this context. Therefore, the request for X, X is not medically necessary".

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

Based on the medical records submitted, medical necessity has not been established for the request of X, X. The claimant has X, symptoms which have been X confirmed X not supported as there is X.

Medical necessity for this request is not supported.

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