

**Applied Resolutions LLC**  
***Notice of Independent Review Decision***

**Applied Resolutions LLC**  
**An Independent Review Organization**  
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***Notice of Independent Review Decision***

**IRO REVIEWER REPORT**

**Date: X**

**IRO CASE #: X**

**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:

- Overturned      Disagree
- Partially Overturned      Agree in part/Disagree in part
- Upheld      Agree

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**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- X

**PATIENT CLINICAL HISTORY [SUMMARY]:**

X who was injured at work on X. The exact mechanism of injury was not provided in the available medical records. X reported X. The diagnoses were chronic neck pain syndrome with bilateral cervical radiculopathy and chronic pain syndrome associated with thoracic back pain with fusion T1 through T4, T4 through T7.

On X, X was evaluated by X DO, for follow-up of X ongoing cervical-thoracic traumatic pain complaints. Dr. X noted they were treating X. X had responded favorably to their combination of medication management. X affect had improved as well. At the time, trigger points in X midthoracic spine with jump signs were elicited. Dr. X was going to recommend X. At the time, X reported X. X at this site would be advised X, as jump signs were elicited with twitch response. On X, X was evaluated by Dr. X for follow-up visit for X ongoing complaints. Dr. X noted that they had to bring X back to the office for X, which were denied under the peer review process. X had a X. X also sustained a X. X continued to have myofascial pain, which had been amenable to the treatment including a X. Unfortunately, X were again identified and had worsened over the prior few months. X had X. Dr. X stated X looked with dismay that the peer doctor did not do their due diligence and see the extent of injuries and the gains that they had already achieved following previous X in this area. Jump signs were elicited across the muscle bellies of the X. These areas were quite taut and tender. X would reserve for

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recalcitrant pain. As a result, Dr. X was going to resubmit for X. This was a simple outpatient procedure X. X was showing good compliance. X was not using X. Continued X would be recommended.

No updated imaging studies were documented.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Regarding X, the Official Disability Guidelines states that it is recommended for myofascial pain caused by X. X is recommended when all the following are present, including focal area of pain in skeletal muscle has recurred, patient has documented improvement in function after most recent previous X, patient reports over X improvement in pain after most recent previous X, and X is performed using X. The cited guideline supports X. In this case, the claimant had X. However, the cited guideline only supports the use of X. Additionally, it is unclear how much improvement there was from X. As such, the request for X is non-certified.”

Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “The Official Disability Guidelines recommend the use of an X. There should be a focal area of pain in skeletal muscle and an evident trigger point reproducing pain on palpation. An assessment should show a X. A X is utilized together with X. The X is performed using a X.

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The use of X is not recommended. The cited guideline requires them to have persistent signs and symptoms of myofascial pain with trigger points, despite the exhaustion of conservative measures and satisfaction of other guideline requirements, before undergoing the procedure. They underwent an X. A prior request for a X was non-certified on X, as the use of other medications other than local anesthesia was not supported. Although they have lingering thoracic pain and muscle spasms or trigger points of the thoracic area despite exhaustion of extensive medical measures in the past including surgery, the request for a X is not warranted, as the use of X is a non-supportive method of treatment during the procedure. The use of X is advised. Hence, the prospective request appealing for X is non-certified.”

Thoroughly reviewed provided records including provider notes and peer reviews.

While patient appears to have trigger points on exam that have responded to X. X have not demonstrated superiority over X. Similar data exists for X.1 Cited ODG criteria also agrees with medical evidence and standard of care.

Thus, X are warranted but not the addition of X.

Prospective request for X is medically necessary and modified to  
Prospective request for X is medically necessary and certified; the  
include X is not medically necessary and non-certified

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL**

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**BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

Thoroughly reviewed provided records including provider notes and peer reviews.

While patient appears to have trigger points on exam that have responded to X. X have not demonstrated superiority over X. Similar data exists for X.1 Cited ODG criteria also agrees with medical evidence and standard of care.

Thus, X are warranted but not the addition of X.

Prospective request for X is medically necessary and modified to  
Prospective request for X is medically necessary and certified; the  
include X is not medically necessary and non-certified  
Modified

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**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- TMF SCREENING CRITERIA MANUAL
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- MILLIMAN CARE GUIDELINES
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- INTERQUAL CRITERIA
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE