



**17119 Red Oak Rd  
Unit # 90333  
Houston, TX 77090  
281-836-6171**

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:**

This case was reviewed by a Board-Certified Physical 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]:**

This X to the X and X. X was diagnosed with a X. The X from X and X. An X did not

show any evidence of X or X. X has been in X. X had X and X and X.

Office visit by Dr. X revealed the claimant complained of X after the X. X revealed X and X and X. There was X with X. The request is for a X and X was requested followed by X and X. Prior denial letters non-certified the request considering the request as a X.

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

According to the ODG, a X is recommended as a diagnostic procedure for X. Furthermore, ODG does not recommend for X and it also only allows X at a time in order to X. In this case, there is documentation that the claimant has X and X. There is documentation that the claimant had prior X, but these were X. The requested X and X is a new level and must be considered X rather than a X. The clinical presentation of this claimant's condition meets the criteria for X.

Therefore, it is the professional opinion of this reviewer that the request is for X is medically necessary and appropriate.

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

**Official Disability Guidelines (ODG) – X**

Recommended prior to X. Not recommended in the X. A X. No more than X. X are not recommended.