US Decisions Inc.
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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 Overtuned Agree in part/Disagree in part

☒ Upheld Agree

Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X when X. The diagnosis was X. On X, X, MD evaluated X for X. X was last seen on X at which time, a X. Overall, the symptoms seemed to X. X complained of X. X factors included X. Associated symptoms included X. The X examination indicated X. Prior relevant treatment included X. X was reviewed and X was noted. The X were X. The assessment was X. X was encouraged to X. Dr. X recommended initiating X. X of the X dated X showed X. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X as requested by Dr. X with X was denied. Rationale: "ODG recommended X. X is X. Based upon the medical documentation presently available for review, the above-noted reference X. There was X. There were X noted to support the requested X. As such, the request for X is non-certified. "On X, Dr. X saw X in a follow-up for X. Overall, the X. A X was administered. The assessment was X. X was recommended X. Per a reconsideration review adverse determination letter dated X, X, MD, upheld the denial for X as requested by Dr. X with X. Rationale: "Per the ODG by X is recommended for X. X is not recommended following X. Based on the X. The patient had X. However, it was noted the patient had X. As such, the request for APPEAL: X is noncertified. The requested X is not medically necessary. The patient has X. Per the ODG by X is recommended for X. X is not recommended following X. The guidelines have X. X is not medically necessary and non certified

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

The requested x is not medically necessary. The patient has X. Per the ODG by X is recommended for X. X is not recommended following X. The guidelines have X. X is not medically necessary and non certified

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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**