

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 Overturned (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. The mechanism of injury was not documented. The diagnosis was cervical radiculopathy. No office visit notes were available for review. An undated appeal letter by an unknown provider documented that X had severe radiating pain into the left upper extremity associated with progressive numbness and weakness that started after a work-related injury that occurred on X. X had been seen by Workers' Compensation X recommending for surgery X. X had exhausted all conservative treatment options and would require X for X. An MRI of the cervical spine dated X, demonstrated at X. This was new compared to the prior MRI done in X. Postcontrast imaging was significantly X. There was no obvious X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, DO, as not medically necessary. Rationale: "ODG by MCG, X, "X," In this case, the claimant has complaints of X. Current medications include X. Physical exam revealed X. There is trace reflexes in the X. Weakness noted in the X. However, guidelines specifically indicate there should be a X. There is no indication the X. Therefore, the requested X is not medically necessary and is not certified." Per a reconsideration review adverse determination letter dated X, and a peer review report dated X, the appeal request for X was denied by X, MD. Rationale: "The request is not medically necessary. This is an appeal of a previous denial which noted "guidelines specifically indicate there should be a X. There is no indication claimant has X." The X appeal report noted the claimant had X. The records did not document X. No X records for the claimant were included for review detailing response and lack of progress with treatment. There was no recent use of X noted. Further, review of the current evaluation did not detail evidence of X. Given these issues which do not meet guideline recommendations, this reviewer cannot recommend certification for the request. Therefore, the request for the Appeal X is not medically necessary. "The requested X is not medically necessary. There are insufficient medical records to document X. No X records for the claimant were included for review detailing response and lack of progress with treatment. There was no recent use of X noted. Further, review of the current evaluation did not detail X. No new information has been provided

which would overturn the previous denials. 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. There are insufficient medical records to document X. No X records for the claimant were included for review detailing response and lack of progress with treatment. There was no recent use of X noted. Further, review of the current evaluation did not detail evidence of X. No new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified

Upheld

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**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**