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**Description of the service or services in dispute:**

X  
**Description of the qualifications for each physician or other health care provider who reviewed the decision:**  
Board Certified X

**Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:**

X

**Patient Clinical History (Summary)**

X who was injured on X. X was X. X was diagnosed with X.

X was seen by X, MD on X. The X. X was X. The pain at X. X reported X. The X and X. X included X. There were X. X examination showed X. X had pain in X. The X was X. An MRI of the X. On X, was X. An appeal for the denial was made. On X presented for X. The pain was X. X was able to X. X rated the X. The pain at the X. X revealed X. X had X. Dr. X opined that X were denied in spite of meeting the Official Disability Guidelines (ODG).

An MRI of the X demonstrated at X. There was X. At X, there was X. There was no X.

Treatment to date included X.

Per a X by X, MD dated X, the request for X was noncertified.  
Rationale, "Recommended as a X." In this case, the patient's X pain

X. There is X in the X. The request is not shown to be medically necessary. As such, the requested X is not medically necessary.”

Per a X, MD dated X, the request for X was noncertified. Rationale, "Recommended as a X." In this case, the patient's X pain diagram indicates that X. There is X. The request is not shown to be medically necessary. As such, the requested X is not medically necessary.”

Per a X, MD dated X, the request for X was noncertified. Rationale, “ODG states X. There is insufficient evidence of the presence of X. The provider has not submitted any compelling information to justify this request and deviate from guideline recommendations. The pain X noted only X. X are not X. The provider has not submitted any new clinical findings or compelling information to justify overturning the prior adverse determination.”

***Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.***

The patient presents with a complex picture of X. There is an X. Then there is a X. Prior reviews noted the X. X is noted X. The patient has X. The patient has X. The X presented by this patient is X. It is probably X. The patient’s description of the pain is that it has a X. The provider’s request is for a X. So, it does X. X, there will no X. This warrants an exception to the guidelines. Given the documentation available, the requested service(s) is considered medically necessary.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ACOEM-America College of Occupational and Environmental Medicine
- AHRQ-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and 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 and Treatment Guidelines
- Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)