US Decisions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 US
Austin, TX 78731
Phone: (512) 782-4560
Fax: (512) 870-8452
Email: @us-decisions.com

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. The diagnoses were X.

As per office visit by X, MD dated X was seen for a X. X presented with X. X was X. X had been going to X. X said that for a X. X-ray reveals X was noted.

Treatment to date included X.

Per a utilization review dated X, the request for X was denied. Rationale: “Per evidence-based guidelines, X is recommended as an X. Per literature, X is defined as X. X associated with X. In this case, the patient complained of X. X presented with X. X still had X. An X-ray revealed X were well Xnoted. A request for X was made. However, there were X reports X and X to fully support the current request, as

there was X. As per X. X are patient requests and X report submitted for review."

Per a utilization review dated X, the appeal request for X was denied. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The indication for X is X. There is X evidence of X. Furthermore, there was X submitted for review. The request is thus not currently supported.

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

The claimant has been followed for X. The claimant had attended X. The claimant had attended X and was recommended to X. There was X. The records did not include a X. The records also did not include a recent evaluation of the claimant. The last evaluation was from X and the X. Therefore, it is this reviewer's opinion that medical necessity is not established.

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)