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***Notice of Independent Review Decision
Amended Letter***

Review Outcome

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:

X

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)

X is a X with date of injury X. X was injured in an X. X was X and X. X was diagnosed with a X and X.

Per records, X was evaluated by Dr. X on X. X reported X. X reported X that continued to X. X had X that provided only X. Examination demonstrated X and X. X and X were X. X with a X and X was recommended.

Per records, X was evaluated by Dr. X on X. X reported X, X. Examination demonstrated X and X remained the same. X and use of X was recommended.

Treatment to date consisted of X, X.

Per records, a peer review on X non-certified X. Rationale: "The review noted the ODG by X recommends X for X and X, X for X and X and X. In this case, it appears the patient has received X for a X. As such, the patient has been X and it is not apparent per the documentation reviewed that this treatment is resulting in X to support continued X.

Per a Peer Review dated X, X, MD non-certified the appeal request for X. Rationale: "This request was non-certified by peer review on X. The report noted that the patient has already X and the request would exceed the guideline criteria. A request for X for the X was submitted on X. During the peer discussion, the provider confirmed that X was not requesting X. As a result, the medical necessity of the request is not established. Therefore, my recommendation is NON-CERTIFY the request for Appeal: X.

Per a utilization review dated X, X, MD non-certified the request for X. Rationale: "The ODG by MCG recommends X for X and X, X and X, and X for X. In this case, it appears the patient has received X for a X. As such, the patient has been X and it is not apparent per the documentation reviewed that this treatment is resulting in X. Additionally, the current request X exceeds the guidelines recommendation. The recommendation is for non-certification."

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

Based on the clinical information provided, the request for X is not recommended as medically necessary. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The request for X would exceed guidelines. When treatment duration and/or X exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of X documented. The patient

has completed sufficient X and should be capable of continuing to X and X. 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
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- 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)