

# US Decisions Inc.

An Independent Review Organization

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## *Notice of Independent Review Decision*

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### *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:***

Board Certified 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 who sustained an injury on X. X and X. The diagnosis included other X.

An X dated X demonstrated findings X. However, X in that X evaluation. X changes were X. There were X of the X. X was noted.

Per a utilization review by X, MD on X, the request for X was non-certified. Rationale: "A peer review performed on X was noncertified the request for X. Additional records were submitted for review. The patient's X is noted to be X which is within guidelines recommendations. However, the records also include an updated X from X which revealed X, without evidence of X.

Furthermore, there were regions of only X. Additionally, although prior X noted X, this study did not note X. Based on these findings, a X is not supported. Therefore, my recommendation is to NON-CERTIFY the request for X.

Per a utilization review by X, MD on X, the request for X was non-certified. Rationale: “The ODG by X recommends X for X and X. Recommended generally if there is a medical need and if the X or X meets X. The appeal X request in this case has been considered not medically necessary and as such this associated request cannot be substantiated. Additionally, this request has been previously denied in peer review on X and it is not apparent that significant new information has been substantiated to support this intervention outside the previous determination. The recommendation is for non-certification.”

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

The ODG recommends X when prescribed as part of a medical treatment plan for conditions that result in X. As X is medically necessary and will result in X, the X is supported. Based on the provided documentation, X is 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
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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)