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## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for a Review by an Independent Review Organization dated X.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated X.
3. Notice of Assignment of Independent Review Organization dated X.
4. Health Plan denial letters dated X and X.
5. X Hospital posting sheet.
6. X XX XX L.L.P. office visit notes dated X, X, X, X, and X.
7. X XX XX office visit notes dated X and X.
8. X XX XX, L.L.P notes dated X
9. Duplicate records.

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

This X patient has requested authorization and coverage for X. The Carrier has denied this request indicating that the requested services are not medically necessary for treatment of the patient's X failed X. A review of record indicates the patient sustained an injury on X. The mechanism of injury is detailed as an approximate X foot X from a X. The current diagnoses are documented as X failed X, X of the X, X, instability of X, X, irreparable X, status post open X (X), status post X with a X. The patient denied any significant past medical history, and a progress report dated X, documented that the patient reported no change in symptoms from the prior visit. On examination of the X, there was tenderness present at the X and X. There were no significant X changes,

no X, no X, and the X examination was unremarkable. There was no X, with X and no X present. Active X was X degrees, X degrees and X degrees. Office x-rays were noted to have revealed XX in good position. The recommended treatment plan included X of the X, X.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

According to ODG, X may be performed for patients who have failed prior X, as well as those who have X and X pain despite prior X management. X is not recommended as a X, but may be recommended for X pain.

There is not enough documentation in the records to justify X. There is documentation of a normal X showing acceptable position of the X. The medical records do not support the need for X at this time. Established ODG criteria are not met.

Therefore, I have determined the requested X, X & X, X - CPT-X, X, X are not medically necessary for treatment of the patient's medical condition.

**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**

**AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

**OTHER EVIDENCE BASED, SCIENTIFICALLY  
VALID, OUTCOME  
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**