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Notice of Independent Medical Review Decision

Reviewer's Report

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

X

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH
PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO
REVIEWED THE DECISION**

X

REVIEW OUTCOME

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]:

This patient is a X with an injury dated of X. Authorization for X has been sought for treatment of X. The rationale provided by the requesting provider for this treatment is that the patient X.

Magnetic resonance imaging (MRI) of the X on X noted an X. X of the X on X were X. The medical record dated X noted that the patient had X and that the pain was X with X, X and X. No other X were noted. This medical record reflected that the physical examination showed X and that X was X in the X with X, X and X tests. The patient's X is X.

The medical record dated X noted that the patient had X of X and that the pain was X with X, X and X. No other X factors were noted. This medical record reflected that the physical examination showed X. The current treatment for the patient were not made clear in this record. It was noted that the patient was currently X, but the X was not documented. Treatments had included the X on X, X, X, X and X. The X on X were noted to X over the duration of the X. Recent objective outcomes from the X, X and X were not made clear.

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

The Official Disability Guidelines (ODG) does not recommend X. This is an option on a case by case basis for X, X, X, X associated with X, and X and the guidelines state that most X now use X, such as X and/or X. ODG states for X, that they are consistent with the intent of X, X, X and encouraging X, and for X and X not otherwise specified, should, at a X, X for a X and clearly result in documented X, X and/or X. Within the documentation provided for review, there was no recent documentation that the patient has seen a X and has a diagnosis of a known X condition with X. Additionally, there was no recent mention of X for any of the X. Finally, there was no recent documentation of associated X and X following the previous X that was sustained to warrant X.

Therefore, I have determined that authorization and coverage for X is not medically necessary for treatment of this patient's 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**
- AHRQ-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**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION):**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**