Maximus Federal Services, Inc.
807 S. Jackson Rd., Suite B
Pharr, TX 78577
Tel: 888.866.6205
Fax: 585.425.5296
Alternative Fax: 888.866.6190

Notice of Independent Medical Review Decision

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

X have determined that a X is not medically necessary for treatment of this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

This Patient is a X who sustained an injury on X and has requested authorization and coverage for X. The Carrier denied this request indicating that it was not medically necessary for the X.

A review of records indicated the enrollee was being treated for X. The Patient's past X history was X. X treatment is not documented in the information provided for review.

The X of the X was a re-read from X and has X of: X. The changes related to the X and X were reported to be X.

The record from the Patient's X visit to X treating physician cited X. The record from this visit noted that the Patient X. The examination revealed X. X was X. There were X and X. X was X. A X was reviewed and noted to show a X. The treatment plan included X.

The X indicated that the Patient had complaints of X. The X was X by X. The examination revealed X. X was X on the X. X was noted to be X.

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

This Patient was being treated for X. The Patient sustained an injury on X and has noted X. The X is X by X. Examination reveals X. X and X were X for X. X was X on the X. X was noted to corroborate X.

However, detailed documentation is not evident regarding trial and failure of recent, reasonable and comprehensive less invasive conservative care measures. The requested procedure is not indicated without failure of less invasive treatments, as noted in ODG with X failed conservative treatment. There is no compelling rationale presented or X noted in the information provided for review to support the medical necessity of this request as an exception to guidelines.

Therefore, X 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:**
X CHAPTER – X FOR X (OR X), X CONDITIONS

☐ **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)**