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 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

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X with an injury date of X. Authorization has been sought for X. The X dated X noted that the patient had X, which was rated at a X. The X showed X to the X with X from X to X. X was X in the X. Treatment to this date included X of X and X of the patient's goals have been X. The plan is to refer the patient to a X.

The X dated X noted that the patient had X, which was rated as a X. The X showed X to the X with X at the X to X. X was X in the X with X. Treatment to this date included X. This record noted X. The plan was to do X.

The X of the patient's X performed on X noted X changes continuing to X at X to X and X changes at X to X. There was a prior X at X to X with X.

The X dated X noted X, which was rated as a X. The X showed X only with a X of X. The plan was to perform a X to X with X as the patient was X about it.

The X dated X noted X, which was rated as a X. The physician examination showed a X of X. There was X to the X with X at the X to X. X was X in the X with X.

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

Regarding the requested X to X with X, Official Disability Guidelines (ODG) state that suggested indicators of X related to X include X to X in the X, a X, and the absences of X and that there is documentation of X, including X, X and X prior to the procedure for at least X to X. The use of X, including other agents such as X, may be grounds to X the results of a X and should only be given in cases of X. X should not be

performed in patients for whom a X is anticipated or inpatients who have had a X at the planned X.

According to the documentation provided for review, the requested X is to be done at the X, which is not supported by ODG. The use of X is not supported unless there is X, which has not been noted with an objective measure in the records provided for review. It is unclear if any X have been used for this patient prior the requested X.

Therefore**,** I have determined that authorization and coverage for X, with X, 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, SIGNS & SYMPTOMS, X (X), X.**

☐ **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)**