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

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

Physician, Board Certified in 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]:

The patient is a X with reported history of injury on X resulting in X with X to include X. Per the provided medical records, the patient's X. Previous treatment has included X, X use, X and X. X documented an X, X in the X, and X. X of the X dated X demonstrated X and X with X, which could produce a X as well as X.

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

The patient is a X with a X with a history of X and X that include X. Per the medical records, there was an injury in X and treatment has included at X, X use and X. X of X dated X shows X as well as X with X at the X of the X that could produce X, furthermore there is evidence of X. The provided medical records do not clearly indicate that X treatment has been attempted for least X nor provide documentation of response to nonoperative treatment. X documented within the provided medical records indicated an X, X in the X and X.

Official disability guidelines (ODG) indicate that indications for X include X for X, X and X or X: X resulting from a defined injury; X of X treatment including X, X and X; X including X/X and/or X and/or X; X, X, and X; X which correlates with the above; X or X and X in X or X; age under X; X; and X should be demonstrated with X and questionable or borderline cases.

In this case, the official disability guidelines indications for the X have not been met as the X is X, the X evaluation of X demonstrates intermediate X or X, there is insufficient documentation indicating that at least X of X has been attempted with X and there is no evidence of a X providing temporary relief X of symptoms. Based upon the standard, the requested X for the X is not considered medically necessary.

Therefore**,** X have determined that authorization and coverage for procedure X with X and X – X – X are 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)**