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

X
Amended X

Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: X

IRO CASE #: X

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:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. X.

PATIENT CLINICAL HISTORY [SUMMARY]:

This member is a X for whom authorization and coverage was requested for X. The Carrier denied coverage for these services on the basis that this item is not medically necessary for treatment of the member's condition.

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

The X consultant explained that a review of records indicated that the member was being treated for X. Past surgical history was X. Conservative treatment included X. The X treating physician report cites that the enrollee is X. The member is still having significant breakthrough pain on the X. The member has X. The examination revealed an active range of motion of minus X to X. Strength is X plus to X out of X. There is X. There is X. X has a X. The treatment plan included a X.

The X consultant indicated that as per the Official Disability Guidelines (ODG), "X"

This member was being treated for X. Detailed documentation is not evident regarding any significantly X. The examination did not document X. There is no indication of X. There is no evidence as to why other than a X. No compelling rationale is presented or extenuating circumstances noted to support the medical necessity of this request as an exception.

Therefore, I have determined that authorization and coverage for X is not medically necessary for treatment of the member'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:**
KNEE AND LEG CHAPTER: KNEE BRACE FOR KNEE AND LEG 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)**