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**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 is a X with an injury date of X, seeking authorization for X on X, X on X.

The medical record dated X noted X. The member takes X. The member has had X on X, X on X, X on X, and X in X. The X examination showed X.

The medical record dated X noted X. The X examination showed X. X is X.

X dated X noted X.

An X of the X dated X revealed an. There was a X. X were seen at X.

X was noted to be X.

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

The X consultant explained that a X. No more than one X. X are not recommended.

### **ODG Criteria**

1. X.

### **Evidence Summary (Section 1)**

X.

ODG Criteria

X.

**Evidence Summary Section 2**

X.

Therefore, I have determined that coverage for the requested the X is not medically necessary for treatment of the member's condition.

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**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:**

As Above

**PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

**TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

**TMF SCREENING CRITERIA MANUAL**

**PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE**

**SECTION 1:**

1. X.

**SECTION 2:**

1. X.

**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**