

Maximus Federal Services, Inc.
807 S. Jackson Road., Suite B
Pharr, TX 78577
Tel: 956-588-2900 ♦ Fax: 1-877-380-6702

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 case concerns a X for whom authorization and coverage for X. The Carrier denied this request on the basis that this service is not medically necessary for treatment of the member's condition.

A review of the record indicates that the member has a history of X. Medical notes dated X explained that the member continues with X. It noted that the member X. It indicated that although the member does show X.

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

The Maximus physician consultant explained that the member is a X who has been diagnosed with chronic moderate-to-severe axial low back, buttock, and lateral thigh pain. The Maximus physician consultant noted that the member's pain is aggravated by side-bending and extension, which is very typical of X. The Maximus physician consultant also noted that records X. The Maximus physician consultant indicated that the member's examination is "X." The Maximus physician consultant noted that the member's symptoms persisted from at least X to X. X were requested to treat the member's condition.

The Maximus physician consultant explained that there is X. However, the X. Further, a X comprehensive review of X.

Therefore, I have determined that the requested X is 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**

**PRESSLEY REED, THE MEDICAL DISABILITY
ADVISOR**

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

TMF SCREENING CRITERIA MANUAL

**PEER REVIEWED NATIONALLY ACCEPTED
MEDICAL LITERATURE**

**OTHER EVIDENCE BASED, SCIENTIFICALLY
VALID, OUTCOME
FOCUSED GUIDELINES**