

**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 who has requested authorization and coverage for a prospective request for X. The Carrier denied this request on the basis that these services are not medically necessary for treatment of the member's condition.

Medical records dated X indicated that the member has X. It noted that the X helped this X after X initial injury and surgeries. It indicated that the member would not be here today. It noted that the member's pain continues to X to X out of X. It indicated that the doctor has implemented effective X. It noted that on this date, the doctor is going to have to raise the member's X. It indicated that the doctor is trying to avoid X. It noted that this delay is the reason for the member's presentation. It indicated that due to the member's American Society of Anesthesiologists (ASA) III status, moderate to severe pain, swelling and sensitivity, the member will require X. It noted that the X. It indicated that X. It noted that however, given the longstanding nature of this disorder, the doctor will start with the X.

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

The Maximus physician consultant noted that Official Disability Guidelines (ODG), Pain, X that a X: X.

The Maximus physician consultant indicated that X. The pain lasts longer and/or is more severe than would be expected from the injury. Additionally, patients experience sensory symptoms (e.g., numbness or hypersensitivity to touch), vasomotor symptoms (e.g., cold hands or feet, skin color changes), excessive sweating or swelling, and/or motor

symptoms (e.g., weakness, decreased range of motion, abnormal muscle tone). In this case, the records support physical examination findings congruent with a diagnosis of X. The member has X. As such, the records support the requested X.

Therefore, the requested prospective request for X is medically necessary for the 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 (PROVIDE A DESCRIPTION)**