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

Notice of Independent Review Decision

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 X. The Health Plam denied this request on the basis that these services are not medically necessary for treatment of the member's condition.

A review of the initial pain evaluation note dated X indicated that the member presented with a complaint of chronic persistent severe axial back pain radiating into X right buttock, leg including numbness and tingling below the knee and into the left foot particularly on the top of the left big toe all following a work injury on X. It noted that the member noticed a sudden pull in X elbow, and in X back, buttock and leg while X. It indicated that the member has had persistent pain despite appropriate physical therapy and rehabilitative medical treatment options. It noted that the member was diagnosed with chronic back pain syndrome with lumbar disk protrusions most notably lumbar X with retrolisthesis and right lumbar radiculopathy with lumbar disk protrusions X associated with chronic back pain syndrome following work injury.

A progress note dated X indicated that the member was treated over a year ago with X.

A progress note dated X indicated that further care of X lumbar disk disruption and persistent right lumbar radiculopathy recently exacerbated with increased activity levels. It noted that we have requested what has helped X in the past. over X months ago, when X had excellent relief of pain, and improved function. It indicted that specifically, the member was able to sit, stand, walk, perform activities of daily living (ADLs) with greater ease. It noted that the member was able to cook, dress in the morning without X significant other. It indicated that today, the member feels the pain is causing X to bend over and X can barely sit for more than 10 to 12 minutes at a time without having to stand up and walk and X has become quite anxious. It noted that unfortunately, neuropathic pain medicines including X were tried with unfortunate side effects, including drowsiness and confusion.

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

The Maximus physician consultant explained that this is a X with a date of injury of X, given a diagnosis of chronic back pain syndrome with right lumbar radiculopathy. The member also has a diagnosis of moderate reactive depression, anxiety associated with chronic pain. Official Disability Guidelines (ODG) and Treatment Guidelines conditionally recommend X. This treatment should be administered in conjunction with X. It is not recommended for treatment of X. X are not recommended as a treatment for axial low back pain or for nonspecific low back pain. X are not recommended.

Therefore, the requested coverage for requested authorization and coverage for a 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:** ODG Criteria for ESIs
- ☐ **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)**