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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 case concerns a X. The Carrier denied this request on the basis that these services are not medically necessary for treatment of the member's condition.

A review of records indicated the member was being treated for X. Past medical history was X. Past surgical history was X.

Conservative treatment included X.

The X magnetic resonance imaging (MRI) of the lumbar spine has impressions of X.

The X MRI of the left hip has impressions of evidence for an X.

The X computed tomography (CT) scan of the lumbar spine has findings of X.

The X MRI of the lumbar spine has impressions of X.

The X electrodiagnostic testing has impressions of X.

The X treating physician report cites back pain. The member is X months status post a X. The member is overall doing okay. The member

has lower back pain and bilateral hip pain that is worse on the left. There is minimal pain of X mid-back. The treatment plan included a X.
The X treating physician report cites X. The pain is moderate rated at X. There is associated X. The member is seeing a different provider for X. The examination (exam) reveals decreased X. The treatment plan included X.

The X treating physician report cites X. The X. The member is using a X for it. The exam reveals that the member X. There is X. The treatment plan included a X.

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

This X sustained an industrial injury on X, is seeking authorization for X. The member presented on X with X. The X. The member is using a X for it. The examination (exam) revealed that the member X. There is X. However, detailed documentation is not evident regarding a recent body mass index (BMI) measurement. Additionally, it is not clearly documented when the member underwent X.) Moreover, in the provided diagnostic imaging studies, there is unclear corroboration of X.

The Maximus physician consultant explained that as per Official Disability Guidelines (ODG), "Recommended as indicated below when all reasonable conservative measures have been exhausted, including other less extensive surgical options. ODG Indications for Surgery X:X
Overall, there is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception to guidelines. Therefore, the requested coverage for X is not 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)**