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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 member is a X for whom authorization and coverage was requested for X. The Carrier denied coverage for these services on the basis that these services are not medically necessary for treatment of the member's condition.

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

The Maximus physician consultant indicated that a review of records indicated that the member was being treated for X. Past medical history was positive for X. Past surgical history was positive for X. Conservative treatment included X.

The Maximus physician consultant noted that the X x-rays of the lumbar spine have thoracic spine findings of X. The X magnetic resonance imaging of the lumbar spine has X.

The Maximus physician consultant indicated that the X x-rays of the lumbar and thoracic spine have impressions of X. The X magnetic resonance imaging of the thoracic spine has findings of X.

The Maximus physician consultant noted that the X treating physician report cites lower back pain that has been present since the date of injury of X when the member X. The member also has thoracic pain with radiative pain to the right and left lateral chest wall. The examination of the thoracolumbar spine reveals tenderness over the X. There is increased pain in X. X are X. X. The treatment plan included X.

The Maximus physician consultant indicated that as per the Official Disability Guidelines (ODG) Guidelines, "A X. A diagnostic X. The member was being treated for X. The member presented with thoracic pain with radiative pain to the right and left lateral chest wall. The examination of the thoracolumbar spine reveals tenderness over the X. There is increased pain in thoracolumbar extension. X are X. X.

The Maximus physician consultant noted that the request was made for X. As noted, the ODG guidelines do not recommend these X. Further noted in the ODG, "Documentation at least X months of X. Detailed documentation regarding a X. There is no clear indication of any X. Moreover, as per the ODG, "Clinical presentation should be consistent with "Facet joint pain, signs and symptoms" referenced above." And further noted, "Signs in the cervical region are similar to those found with spinal stenosis, cervical strain, and discogenic pain. Characteristics are generally described as the following: (1) X(2) X (3) X (4) X.

The Maximus physician consultant indicated that in this specific case, the member's examination demonstrated tenderness over the X. There is increased pain in the thoracolumbar extension. X are X. X. There are noted X. The provided thoracic spine imaging studies X. There is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception to guidelines.

Therefore, I have determined that authorization and coverage for 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:**

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

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

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION):**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME**

FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)