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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 this request 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.

1. The Maximus physician consultant explained that a review of the progress note dated X indicated that the member presented for evaluation of lower back pain with initial date

of injury of X. It noted that the member was injured while X was X. It indicated that subsequent magnetic resonance imaging (MRI), approximately X years ago showed a X. It noted that the member X. It indicated that the member initially had a X. It noted that the member is actively employed, working X hours per week, walks for a half mile per day, does yard work and is a caregiver to X mother. It noted that the member does have radiative pain down the right leg anterolateral aspect to the right heel and right great toe. It indicated that there was referred pain down the left hip, left buttock and into the left groin. It noted that the member was diagnosed with lumbar radiculopathy, post lumbar laminectomy syndrome and has a history of grade 1 spondylolisthesis from X.

The Maximus physician consultant indicated that in this case, the records report ongoing multiple years of treatment with successful functional ongoing status with continued medication refills over time. The medical records support that the member has X. X is supported under American College Of Occupational & Environmental Medicine (ACOEM) and Official Disability Guidelines (ODG) when other conservative management has been tried for at least X months and found to be inadequate or not tolerated. The X is medically necessary for treatment of chronic pain, chronic regional pain syndrome (CRPS) or spasticity not responsive to other management. Given that the records describe X.

Therefore, I have determined that authorization and coverage for X is medically necessary for treatment of this 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)**