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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 year-old X with a date of injury of X. Magnetic resonance imaging (MRI) of the member's lumbar spine on X noted a X.

On X and X, X were done with reported "X". The only progress note submitted was from X. At this visit, the member stated that X had low back pain that had worsened since X. The progress note stated that the member had declined medications due to concerns over side effects and had done X. It indicated that the member reported that X pain level was a X to X out of X. A transcutaneous electrical nerve stimulation (TENS) unit was stated to have not been helpful. The X was subjectively helpful. The physical examination at this visit noted tenderness to the lumbar spine, a positive straight leg raise (SLR) on the right and left, and range of motion to be decreased with trigger points palpated. On X, a request for X was made.

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

Official Disability Guidelines & Treatment Guidelines (ODG) ODG states "X." ODG also states "X."

The Maximus physician consultant indicated that within the documentation available for review, there is no current and specific objective neurological findings to document a specific radiculopathy that can be corroborated with the advanced imaging. The Maximus physician consultant also indicated that instead the straight leg raise is noted in general terms as being "X." The Maximus physician consultant further

indicated that while the provider noted X improvement in the pain from the X. The Maximus physician consultant noted that also, “a clinically meaningful duration" was not defined and corroborated to ensure it is greater or equal to X weeks. The Maximus physician consultant also noted that there was no currently noted X. The Maximus physician consultant indicated that no special circumstances and exceptional factors were noted recently that would supersede and disregard the ODG recommendations.

Therefore, I have determined that the currently requested X are not 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:**

Epidural Corticosteroid Injection

☐ **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)**