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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

X

## PATIENT CLINICAL HISTORY [SUMMARY]:

The member is a X with X after a work-related X. X carries diagnoses of low back pain (unspecified) and closed fracture of the coccyx. Records from X through X indicate persistent coccygeal pain consistent with coccydynia. X underwent X. At follow-up on X, X reported initial X pain relief following the procedure, with approximately X sustained relief at the time of visit. X perceived that the X "X" and reported no procedural complications or side effects.

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

The Maximus physician consultant explained that the member has X. The Maximus physician consultant noted that the member has demonstrated substantial and durable benefit (X initial, ~X ongoing relief) with no adverse effects from the X. The Maximus physician consultant also noted that current peer-reviewed literature supports X as a reasonable, effective, and safe intervention for X. The Maximus physician consultant indicated that the procedure fits squarely within the stepwise, guideline-style management of X.

The Maximus physician consultant explained that given the prospective clinical trial data, multiple supportive case series and reviews in X, and the clear, reproducible benefit in this member, one would not classify X as purely investigational in X case. The Maximus physician consultant noted that it is a minimally invasive, evidence-supported option for X.

Therefore, I have determined that the requested X is medically necessary for treatment of this member's condition.

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**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)**