Maximus Federal Services, Inc.
807 S. Jackson Rd., Suite B
Pharr, TX 78577
Tel: 888.866.6205 ◆ Fax: 585.425.5296 ◆ Alternative Fax: 888.866.6190

Notice of Independent Review Decision

807 S. Jackson Road., Suite B
Pharr, TX 78577
Tel: 956-588-2900 ◆ Fax: 1-877-380-6702

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 the progress note dated X indicated that the member presented for follow-up for X lumbar back sprain. It noted that the member reported that sitting, standing, lifting and walking for long periods of time increased X pain. It indicated that the member reported that X was X as needed to relive X pain. It noted that the member was not currently working due to X limited physical condition. It also noted that the member reported that X pain level was at X out of X in severity. It indicated that the member's current medications were X. It also indicated that a X was performed. It noted that the diagnosis was sprain of ligaments of lumbar spine.

The Carrier has indicated that these services are not medically necessary for treatment of the member's condition. The Carrier noted that X and results, medical necessity cannot be established.

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

The Maximus physician consultant indicated that the records provided for review report that a X. The Maximus physician consultant also indicated that a X note reported that the member had low back pain and that X had X days benefit from X. The Maximus physician consultant noted that the examination on this date was reported to X. The Maximus physician consultant indicated that "X" were noted.

The Maximus physician consultant explained that the Official Disability Guidelines (ODG), X, note in regard to X: X.

The Maximus physician consultant indicated that in this case, the member's condition is described as a chronic low back pain condition and does not represent an acute or subacute radicular pain syndrome. The Maximus physician consultant noted that previous treatment has included X. The Maximus physician consultant indicated that the degree of any functional improvement was not quantified. The Maximus physician consultant explained that ODG does not support unless there is X to X weeks improvement. The Maximus physician consultant indicated that there were no physical examination findings reported in the records provided for review that were consistent with acute or subacute radicular pain syndrome. The Maximus physician consultant explained that a such the medical records do not indicate findings that are congruent with support of an X.

Therefore, the requested prospective request 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)**