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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 who sustained an industrial injury on X. Authorization for X has been requested for the treatment of a diagnosis of sprain of ligaments of the member's lumbar spine.

Prior diagnostic testing included magnetic resonance imaging of the lumbar spine dated X, which demonstrated X.

The member's past medical history was X and X past X. According to the information provided for review, the member is a X. The member's previous treatment includes X.

A progress report dated X noted that the member had low back pain and stated that X felt as if X lower back is sitting on X hips. At this visit, the member reported that X has been taking medications due to surgery X completed a few weeks prior to X injury; however, had no relief. The member's pain was indicated to be radiating from the lower back to the bilateral hips/buttocks and legs, constant, and severe. The examination revealed X. There was pain with range of motion. X were X. There was X. X was X. Straight leg raise test was X.

Request for reconsideration dated X reported that the member sustained a work-related injury on X when X. It noted that the member has constant, severe pain that is shooting, throbbing, achy, and sharp with tingling, weakness in the bilateral legs, stiffness pressure, soreness and spasms, which is aggravated by lying down, sitting, bending, walking, and physical activity. It reported that the pain affects the member's

activities of daily living such as work, sleep patterns, family and social life, and overall quality of life. The member was noted to have X. The treatment plan included an X.

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

Per the Official Disability Guidelines & Treatment Guidelines (ODG) "X"

The Maximus physician consultant indicated that the member presented with complaints of low back pain that radiates from the lower back to the bilateral hips/buttocks and legs, is constant, and severe and has been ongoing for greater than X weeks. The Maximus physician consultant also indicated that the member's examination revealed X. The Maximus physician consultant explained that these findings corroborate that the radiculopathy is along the X.

The Maximus physician consultant noted that this request is for an X. The Maximus physician consultant also noted that pain affects the member's activities of daily living such as work, sleep patterns, family and social life, and overall quality of life. The Maximus physician consultant indicated that the member is noted to have X. The Maximus physician consultant explained that however, these treatment modalities were not documented to have been recent. The Maximus physician consultant also explained that the requested X. The Maximus physician consultant indicated that these are mandatory guidelines per the ODG.

The Maximus physician consultant noted that moreover, the request is requested to be "X" indicating X. Per ODG, "X." The Maximus physician consultant explained that X.

Therefore, I have determined that 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:**

☐ **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)**