Maximus Federal Services, Inc.
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 for whom authorization and coverage for X. The Carrier denied this request on the basis that this service is not medically necessary for treatment of the member's condition.

A review of the record indicates that the member has been diagnosed with radiculopathy, lumbar region, radiculopathy lumbosacral region, spinal stenosis, lumbar region with neurogenic claudication, other intervertebral disc replacement lumbar region, other low back pain, and muscle spasm of back. Medical records dated X explained that the member continues reporting lower back pain with radicular symptoms to X bilateral hips, buttocks, and thighs. It noted that the member experiences numbness and tingling in bilateral legs worse on the right, and X is having trouble walking. It also noted that the member reported mid back pain spanning the entire back with radicular symptoms to the ribs.

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

Official Disability Guidelines & Treatment Guidelines (ODG), X: X are not routinely recommended unless there is evidence of an acute pain exacerbation after a symptom-free period. This criterion is based on an emerging concept that the true natural history of lumbar radicular pain due to intervertebral disc herniation often follows that of a relapsing remitting disease, with temporary occurrences of symptoms over the years. (1) Evidence indicates that X should be restricted to patients with continuous radicular pain for less than X months. (2) Therefore, the

following criteria should be considered: X should require documentation that previous X produced a minimum of X pain relief and improved function for at least X weeks. X is better supported with documentation of decreased medication requirement after the previous procedure. Based on general consensus, no more than X per region should be administered within a X-month period.

The Maximus physician consultant explained that the National Imaging Associates (NIA) guideline notes X is supported for pain causing functional disability in setting of failed conservative treatment. The Maximus physician consultant noted that a study report X may provide short term benefit for radicular pain in cases of nerve root impingement that has X. The Maximus physician consultant also noted that the presence of radicular pain should be confirmed based on physical examination findings.

The Maximus physician consultant explained that a similar reported explained that X may provide short term benefit for radicular pain in cases of nerve root impingement that has X. The Maximus physician consultant also noted that the presence of radicular pain should be confirmed based on physical examination findings. The Maximus physician consultant also noted that a review of the record indicates that the member has been diagnosed with lumbar pain. The Maximus physician consultant indicated that the evaluation on X reports ongoing low back pain, pain was in the mid and low back with radiation into the bilateral buttocks. The Maximus physician consultant noted that the member's pain was rated X out of X and a physical examination reported that sensory bilateral upper and lower extremities was within normal limits for light touch.

The Maximus physician consultant explained that the magnetic resonance imaging (MRI) dated X, reported findings of X. The Maximus physician consultant noted that there was X. The Maximus physician consultant also noted that there is X. The Maximus physician

consultant indicated that there was X. The Maximus physician consultant also indicated that there was X.

The Maximus physician consultant explained that the member's evaluation dated X reported low back pain. The Maximus physician consultant noted that there are reportedly radicular symptoms of the bilateral hips, buttocks and thighs and the member's pain was described as constant. The Maximus physician consultant indicated that the physical examination described X Patrick FABER test and seated straight leg raise. The Maximus physician consultant noted that there was irregular gait, sensation was grossly intact, and there was normal motor tone and strength.

The Maximus physician consultant explained that the records reflect low back pain but does not demonstrate findings on examination of a dermatomal distribution of radiculopathy in support of X. The Maximus physician consultant noted that there is no documented sensory, reflex or motor neurologic change in a radicular dermatomal pattern in support of X. The Maximus physician consultant indicated that the medical necessity of the treatment of X is not supported.

Therefore, I have determined that X only is 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**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**