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

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Notice of Independent 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)

I have determined that X is not medically necessary for treatment of this member's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

This case concerns a X with a work-related injury dated X involving the low back and left lower extremity. The member's diagnoses include intervertebral disc disorder with lumbar radiculopathy, unspecified injury of muscle/fascia/tendon at the left thigh level, and strain of the muscles, fascia, and tendons of the lower back.

At the clinical evaluation dated X, the member reported constant low back pain rated X out of X, described as sharp in quality, with radiation into the left leg. The member's symptoms were aggravated by prolonged standing, prolonged sitting, walking, use of stairs, and bending activities, resulting in interference with daily activities. A examination demonstrated X. The member had reportedly X. Current treatment included X, and referral to X was planned.

A lumbar spine MRI dated X demonstrated X. A Letter of Medical Necessity dated X requested authorization of the X, stating that X. Additional appeal letters dated X and X argued that the X. However, the submitted documentation did not establish that X.

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

The X physician consultant explained that the member has documented X. These findings support X. However, the issue is not whether X, but whether X.

ODG X. The records do not document failure of X. There is also no documentation that the member cannot safely X.

The treating provider's letter describes advantages of X, but it does not provide member-specific evidence that those features are required for this member's condition. Additionally, the record reflects X. The requested X appears convenience-based rather than medically necessary.

Therefore, I have determined that the requested X 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 (PROVIDE A DESCRIPTION):**

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

X