CASEREVIEW
8017 Sitka Street
Fort Worth, TX 76137
Phone: 817-226-6328
Fax: 817-612-6558

February 21, 2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Purchase of Replacement Hearing Aids (bilateral ears)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board Certified in Otolaryngology with over 35 years of experience.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Overturned (Disagree)
Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
On XXXX, the claimant contacted XXXX and reported XXXX hearing aids had been XXXX. XXXX has been without hearing aids since that time. Replacement hearing aids have been requested.

On XXXX, XXXX performed a UR. Rationale for Denial: While it is noted the patient XXXX hearing aids, provided in XXXX, an updated evaluation of the patient and rationale, including the patient's lifestyle, would need to be noted prior to consideration for a more advanced and more expensive model as opposed to an adequately effective midpriced model.

On XXXX, XXXX performed a UR. Rationale for Denial: The hearing aid replacements were denied by utilization review due to lack of a recent clinical assessment of the claimant's hearing. The available records did note that the claimant did not have access to hearing aids as XXXX had XXXX. However, the records did not include a recent clinical evaluation of the claimant to include updated audiograms to support the hearing aid request as medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse determinations are overturned. I reviewed all available records. Hearing aid placement was denied on XXXX due to lack of recent clinical assessment. Provided medical records show audiometric evaluation on XXXX. This audiogram shows bilateral high-frequency sensorineural hearing loss which is clinically significant and would benefit from hearing aids. It is my opinion that

with the recent assessment of XXXX, at all required documentation is been performed and reimbursement for hearing aids is appropriate.

PER ODG:

Hearing aids are recommended for any of the following conditions:
(1) Conductive hearing loss unresponsive to medical or surgical interventions. (Conductive hearing loss involves the outer and middle ear and is due to mechanical or physical blockage of sound. Usually, conductive hearing loss can be corrected medically or surgically.)
(2) Sensorineural hearing loss. (Sensorineural or "nerve" hearing loss involves damage to the inner ear or the 8th cranial nerve. It can be caused by aging, prenatal or birth-related problems, viral or bacterial infections, heredity, trauma, exposure to loud noises, the use of certain drugs, fluid buildup in the middle ear, or a benign tumor in the inner ear.) or
(3) Mixed hearing loss (conductive hearing loss coupled with sensorineural hearing loss). (Cigna, 2006) (Chisolm, 2007)

Hearing aids should be recommended by an otolaryngologist or a qualified audiologist, and prior authorization should be required for hearing aids costing more than $1,500 per ear, including hearing aid evaluation, fitting and purchase of hearing aids, once every four years. (CMS, 2014)

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
- ☐ AHCPR- 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
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)