Becket Systems
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Notice of Independent Review Decision

IRO REVIEWER REPORT
Date: 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:

☐ Overturned Disagree

☐ Partially Overtuned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X stated X started having pain after X. The diagnosis was nonrecurrent bilateral inguinal hernia without obstruction or gangrene. On X, X was evaluated by X, MD for bilateral inguinal hernias. X rated pain X at that time. The pain was coming and going. Right testicle was swollen for a day after the occurrence. The pain worsened after walking for long periods of time. X denied nausea and vomiting. X

felt that X pain levels had gradually improved, however, X continued to have discomfort with lifting and extended periods of standing. X had X in the past with lap band placement in X and explant in X. There was X present. On examination, X blood pressure was 159/99 mmHg, weight was 220 pounds and BMI was 29.84 kg/m2. Abdominal examination revealed abdomen was X. It showed X. The assessment was X. They discussed treatment options including X. The hernia(s) were symptomatic, it was recommended that X. An X was discussed, including pros and cons of each. X would like to proceed with X. X would be booked for a definitive X dated X revealed bilateral fat-containing inguinal hernias, right greater than left, extending slightly into the right scrotum. There was no associated bowel herniation or bowel obstruction present. There was no acute intra-abdominal or pelvic process seen. Specifically, there was no bowel obstruction, abscess, or acute diverticulitis. There was a normal appendix seen. There was no obstructive uropathy present.Treatment to date included X.Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Regarding X, Official Disability Guidelines state Indications for X Include X detected on routine physical examination. X is “not recommended based on a lack of randomized controlled trials demonstrating improved clinical outcomes.” It was further stated that “Guidelines support X when clinically indicated, Guidelines do not support X since there is no evidence of superiority compared to standard surgical procedure. In this case, the requesting surgeon has no exceptional factors like documented disability of vision or fine manipulation of the hands that would prevent a standard X. Since there is no guideline support and no exceptional factor, the request for X is non-certified.”X, MD wrote an appeal letter on an unknown date for the request of a X which was denied.Per a reconsideration / utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Peer discussion with Dr. X noted that X approach will provide better results with X and faster recovery. In X opinion, this is the standard of care for the patient condition. The records provided show that the claimant has bilateral Inguinal hernia right greater than left. The attending provider is planning to perform a X, X is not considered medically necessary due to the lack of improved outcome based on the ODG criteria provided. Therefore, the requested X is not considered medically necessary for this claimant based on the aforementioned criteria. Recommend non-certification.”The requested X is not medically necessary as the guidelines do not support the use of X given the lack of improved outcomes. No new information has been provided which would

overturn the previous denials.X is not medically necessary and non certified

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

The requested X is not medically necessary as the guidelines do not support the use of X given the lack of improved outcomes. No new information has been provided which would overturn the previous denials. X is not medically necessary and non certified
Upheld

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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☐ **PRESLEY 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)**