**Becket Systems**
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## *Notice of Independent Review Decision*
## *Amendment X*

**IRO REVIEWER REPORT**
**Date:**X; Amendment 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. The injury was sustained when X was X. X suffered X. The diagnosis was male erectile dysfunction, unspecified and induration penis plastic. X was seen by X, MD / X, MD on X for erectile dysfunction. X presented for X. On examination, X blood pressure was 151/87 mmHg. X had normal X. Body mass index (BMI) was 34.62 kg/m2. X examination revealed X. X underwent X. X was performed with X. There was X. X showed left sided X degrees with X. X was reversed successfully with X. X was advised to use X. Regarding considering X, Dr. X recommended X. Second line options to be considered was X. The other second line option was X. The third line option should be considered which was X. X opted to proceed with X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Official Disability Guidelines does not specifically address the requested X. Per evidence based literature (X. Conclusion:X." In this case, there were no significant abnormal findings on examination to support the request. Therefore, this is not medically necessary. Thus, this is not certified.” Per a reconsideration adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Official Disability Guidelines does not specifically address the request. Per evidence-based literature, X, "X. X continues to be a life-changing procedure for patients, and it is imperative for surgeons to be up to date on the latest developments and research in order to provide the best functional outcomes for those they take care of X. New Advancements in X." Per X, "X  continue to be an important treatment for X. While the volume of X." In this case, the patient has medically X. X failed X. However, X was now implemented. No results of the X have been presented. As the X is considered third line therapy, without knowledge of the results for the X, the third line therapy would not be approved. Therefore, this would not be considered medically necessary and not certified.” The requested procedure is not medically necessary. X have been trialed. However

results of this trial have not been submitted for review. As such, the requested procedure is not medically necessary. 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 procedure is not medically necessary. X have been trialed. However results of this trial have not been submitted for review. As such, the requested procedure is not medically necessary 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**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**