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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 Overturned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

• X

PATIENT CLINICAL HISTORY [SUMMARY]:

X with a date of injury X. The mechanism of the injury was described as X. X was diagnosed with other articular cartilage disorders, right hip (X). X was seen by X, PA on X for right hip pain. X presented with X. The pain was rated X. The pain was described as X. The symptoms were increased with X. The symptoms were X. The pain X. X was limited with activities of daily living. On examination of the right hip, range of motion revealed X. There was X. The diagnosis was other articular cartilage disorder, right hip. Treatment plan was to proceed with X. X would need X. An MR arthrogram of the right hip dated X showed X. an MRI of the right hip dated X showed X. Treatment to date included X. Per a utilization review adverse determination letter dated X; the request for X. CPT codes: X:X ; 4. X was denied by X, DO. Rationale: "The Official Disability Guidelines recommend X. On X, presented to the office complaining of right hip pain rated X associated with muscle spasms and aggravated by activities of daily living. On assessment, X has X. However, X is already X years old and has a BMI of 35. Thus, the request for X. CPT codes: X is noncertified. The Official Disability Guidelines recommend X. On X. Presented to the office complaining of right hip pain rated X associated with muscle spasms and aggravated by activities of daily living. On assessment, X has X. However, the requested X is not certified. Thus, the request for X is non-certified. The Official Disability Guidelines recommend X. On X. Presented to the office complaining of right hip pain rated X associated with muscle spasms and aggravated by activities of daily living. On assessment, X has X is not certified. Thus, the request for also requesting for X: X is noncertified. The Official Disability Guidelines recommend X. On X. Presented to the office complaining of right hip pain rated X associated with muscle spasms and aggravated by activities of daily living. On assessment, X has X. However, the requested X is not certified. Thus, the request for X is noncertified. Peer to peer was not successful. Because an adverse determination for surgery has been rendered, an adverse determination for any associated pre-operative clearance is also rendered. Per a reconsideration

/ utilization review adverse determination letter dated X; prior denial was upheld by X, MD. Rationale: “Official Disability Guidelines conditionally recommends X. Physical exam of right hip noted X. Treatments have included X. Records indicate prior denial of the request due to X age and a BMI of 35. Records do not indicate the X, and X is noted to have a BMI of 35, which is not consistent with guidelines. Therefore, the appeal request of X. Per CPT codes:X, is non-certified. Official Disability Guidelines conditionally recommends X. Progress note, dated X, indicated X has had continued X. Physical exam of right hip noted X. The request is not medically necessary due to non-certification of requested X, and unable to modify the request without peer-to-peer discussion. Therefore, the appeal request of X, is non-certified. Official Disability Guidelines conditionally recommends X. Guidelines indicate the use of X. Progress note, dated X, indicated X has had continued X. Treatments have included X. The request is not medically necessary due to non-certification of requested X. Therefore, the appeal request of X :X, is non-certified. Official Disability Guidelines recommends X. Guidelines indicate the use of X. Progress note, dated X, indicated X has had continued X. Physical exam of right hip noted X. The request is not medically necessary due to non-certification of requested X. Therefore, the appeal request of X: X, is non-certified.” The requested X is not medically necessary. The medical records that demonstrate that the patient has a BMI of 35. The patient's age is greater than X. There was X on examination. The requested procedure is not consistent with the guidelines. No new information has been provided which would overturn the previous denials. 1.X.X, 2.X, 3. Also requesting for X:X, 4. X are 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. The medical records that demonstrate that the patient has a BMI of 35. The patient's age is greater than X. There was X on examination. The requested procedure is not consistent with the guidelines. No new information has been provided which would overturn the previous denials. 1.X.X, 2.X, 3. Also requesting for X:X, 4. X are 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

☐ 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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL