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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 Overturned 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. A X. The diagnoses were contusion of the right buttock with sciatic nerve contusion and right sacroiliac joint contusion sprain/strain. X was seen by X, MD on X for a follow-up of injuries sustained at work. X had undergone X. The MRI scan done on X revealed X. X had been out of work since the date of injury. X had complaints of X. X also had an MRI of the lumbar spine X. Examination of the lumbar spine still revealed a X. X had good flexion to X degrees with terminal pain at the lumbosacral junction with X degrees of extension, again with terminal pain. Lateral bending to the left caused right-sided buttock pain. X still had a X. X has X. X had X. Recommendations were to discontinue X. Dr. X felt the sacroiliac joint seemed to be the primary pain generator at the time. The plan was to try getting approval for a X. Treatment to date included X. Per a Notice of Adverse Determination WC Non-Network letter dated X by X, MD, the request for X was non-certified. Rationale: "The Official Disability Guidelines supports a X. However, MRI is preferred. There is a treatment plan to obtain a X. However, no highlights have been noted on the existing CT scan or MRIs already performed to expect any significant information to be obtained with a X. Accordingly, this request for a X is not supported. "Per a Notice of Adverse Appeal Determination WC Non-Network letter dated X by X, MD, the request for X was non-certified. Rationale: "Consultation with the Official Disability Guidelines would recommend obtaining a X. This claimant does not have any of these conditions, but rather complaints of sacroiliac joint pain. The previous review did not certify this request as well indicating that no abnormalities were noted on previous imaging studies to support obtaining additional information from a X. Accordingly, this request for a X is not supported. Recommend non-certification. "The requested X is not medically necessary. A prior CT scan of the right hip and MRI scan of the right hip and lumbar spine do not detail of the sacroiliac joints. A X is not supported by the medical literature or guidelines for sacroiliac joint. 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. A prior CT scan of the right hip and MRI scan of the right hip and lumbar spine do not detail of the sacroiliac joints. A X is not supported by the medical literature or guidelines for sacroiliac joint. 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

☐ 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