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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: 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:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part) .

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X.

PATIENT CLINICAL HISTORY [SUMMARY]:

This X who sustained an industrial injury on X, is seeking authorization for X. The Health Plan denied this request indicating that it was not medically necessary for the member's medical condition.

A review of records indicated that the member was being treated for X. The member's past medical history was X. The member's past X.

The X MRI of the X.

The X x-rays of the right hip are noted to X.

The X treating physician report cited localized pain to the member's right X. The physician noted X. The physician also noted X. The examination (exam) of the right hip revealed X.

There is X. X-rays of the right hip are noted to show X. The treatment plan included a X.

The X treating physician report cited X. The member's pain has essentially remained unchanged, and X is significantly limited in X ability to accomplish daily activities. The exam of the right hip X. The treatment plan is again for the X.

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

The Maximus physician consultant explained that as per Official Disability Guidelines (ODG) the requested procedure is "Not recommended for X. However, X is recommended as an option for short-term pain relief in X."

However, ODG guidelines do not recommend X. There is limited published, large-scale, long-term peer-reviewed literature that shows X.) There is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception. Therefore, the requested authorization and coverage for an X not medically necessary for the treatment of the member's condition.

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 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:**

Hip and Pelvis Chapter- Injections For Hip And Pelvis Conditions and
Intra-Articular Corticosteroid Injection For Hip And Pelvis Conditions

☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**

☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE**

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