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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** is a X who was injured on X. X had a bulge in the X. There was X . X underwent X. The diagnosis was left inguinal neuralgia. X was seen by X , MD on X for complaints of pain in the X. X was status X. The first surgery was X or X. The X was on X. The pain went up to a X. The pain was present since the X. The location was X. The severity of the pain was X. The pain was constant and occurred every day. The mechanism of the injury was X. Attempted treatments included X. When the pain X. X was confined to the X. Examination revealed X. X examination was X. The plan included X. X consulted X, MD on X for a follow-up X. X continued to experience severe pain in the X. X has no complaints on the X. The X. It occurred in certain positions unpredictably. X was unable to X. X had been taking the X as prescribed but could not tell if it was effective. Overall, X symptoms had improved some but not enough for X to return to X regular activities. On examination, the abdomen was X. X was noted below the X. Per Dr.X, typical X. It had been X. There was no evidence of X. X was not able to X. Consultation with the pain management was discussed. Treatment to date included X.Per a utilization review adverse determination letter dated X by X, MD, the request for X was non-certified. Rationale: "ODG does not directly address X, it is stated that, "Treatment options for X." A successful peer-to-peer call with X, MD was made at X. In this case, however, it was determined on peer-to-peer that the proposed procedure is not X. ODG guidelines do not address that procedure. I asked Dr. X if X was aware of peer-reviewed literature that would support it. After the peer-to-peer discussion, Dr. X submitted one paper for review by e-mail (X. Transition from X: Method Description and Results from a Retrospective Chart Review of the X Doi:X However, this study did not specifically address X. Therefore, the request for X is not shown to be medically necessary and non-certified." The clinical basis for

determination was as follows: “The patient is a X. The patient was diagnosed with unspecified lower abdominal pain, and status post laparoscopic right inguinal hernia repair, and open left inguinal hernia repair on X. On X the patient reported X. Pain radiated around the incision and into the X. On physical examination there was X. On X the patient reported X. X was proposed. “Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. The specific medical or dental reasons for the resolution were as follows: “Regarding X , ODG notes that regarding X. A systematic review of X. X can be considered only when refractory pain persists despite X. In this case, a plan for X as part of the same procedure is noted. Upon discussion, the provider notes good personal success with this procedure and notes that if it is not successful it is repeated after X months. There is no specific high-level evidence-based research submitted supporting the long-term efficacy and safety for use of X. Current evidence-based guidelines recommend other procedures for this condition that require a X before they would be approved. Thus, the medical necessity of this request is not established. The recommendation is to deny the X.” The clinical basis for determination is as follows: “Operative report dated X indicates that the claimant underwent X. Initial office visit report dated X indicates that the claimant presents for evaluation of the X. The claimant complains of X. The claimant is status post repeat X. The first surgery was in X  or X  and the X. The claimant notes the pain goes up to a X and radiates from the X. The claimant describes constant and daily symptoms. The claimant has tried X. The claimant reports X. The claimant has a history of X. On examination, there is X. The genital exam is deferred. On assessment, the provider notes the X. The provider recommends X. Utilization review peer reviewer's response report dated X indicates that X was noncertified. The reviewer notes the proposed procedure is not an X. Thoroughly reviewed provided documentation including provider notes and peer reviews. Patient with continued X. Possible that having pain related X. Possible that could benefit from

respective X. However, provider's request for X. The prior cited review as well as a literature search were performed and as peer reviews state, there is no high quality evidence for X.X  are indicated but not X. 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:**

Patient with continued X. Possible that having pain related to X. Possible that could benefit from X. However, provider's request for X are investigational treatments not supported by evidence outside of case reports. The prior cited review as well as a literature search were performed and as peer reviews state, there is no high quality evidence for X are indicated but not X. 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**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**