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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 who was injured on X. No office visit(s) or imaging studies were available in the provided medical records. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "According to the records, the claimant sustained an injury when X. The diagnosis included a sprain of the right hip. The work status was undisclosed. Prior treatments included X. An X was performed on X which revealed X. An MRI was also performed on X showing X. As per the progress report by X, D.O. on X, the claimant complained of right hip pain. Physical examination of the right hip revealed X. Regarding the request for X, the Official Disability Guideline recommended X-ray for chronic hip pain. The Official Disability Guideline and X. Proceeding with the request for X is not indicated. Medical records revealed that the claimant has chronic right hip pain and X and they underwent X on X. Considering that the claimant already had an advance imaging study on the right hip, this request would not be warranted as there was no rationale to perform a X; therefore, the prospective request for X is non-certified. "Per an appeal review adverse determination letter dated X, the request for X was noncertified. Rationale: "The prior non-certification in review X was based on the claimant already having an advance imaging study on the right hip, this request did not warrant as there was no rationale to perform a X. The provider, X, D.O., submitted an appeal on X. Based on the submitted medical records, the claimant sustained an injury due to a X. They were diagnosed with a sprain of the right hip. Their work status was

undisclosed. Prior treatments included X. An X dated X revealed X. An MRI of the right hip dated X showed X. According to the progress report by X, D.O. dated X, the claimant presented with right hip pain. Physical examination of the right hip revealed mild tenderness to palpation, active range of motion with flexion at X degrees, external rotation at X degrees, internal rotation at X degrees, and positive with impingement sign. They voiced understanding that the radicular symptoms were from the lumbar spine, and not the hip proper, however, they declined anything invasive at this time. The procedure billing/request form indicated that the request was for an X. The provider was appealing the prior determination at this time. The Official Disability Guideline state that X. X is contraindicated following X. However, X is recommended as an option for short-term pain relief in X. X should be X. X is not recommended. A search from Official Disability Guideline, PubMed, and ACOEM failed to reveal any indications of X. Per the submitted documentation, the request is partial. The claimant experienced hip pain, corroborated by mild tenderness to palpation and positive impingement sign. The X. The prior treatment has included X. Proceeding with an X. However, there were no exceptional factors that would support X. However, as X was unable to reach the treating physician to discuss treatment modification, the request remains not certified at this time. therefore, the request for X is non-certified. “The requested procedure is not medically necessary. Based on the submitted medical records, the proposed X is not supported by the medical records and/or the associated guidelines. No new information has been provided which 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 procedure is not medically necessary. Based on the submitted medical records, the proposed X is not supported by the medical records and/or the associated guidelines. No new information has been provided which overturn the previous denials. X of the right hip to include 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