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# Notice of Independent Review Decision

## IRO Reviewer Report

X; amended X

**IRO Case #:** X

**Description of the service 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/Denied

**Information Provided to IRO for Review:**

**X**

**Patient Clinical History [Summary]:**

This is a X with a diagnosis of X - pain in the left hip. The request is for the coverage of X.

A left hip Magnetic Resonance Imaging on X showed X.

On X the member reported neck, back, left hip, and left knee pain. Allergies included X. Pertinent medications include X. On physical examination, the left hip flexion was weak compared to the right. The range of motion was painful.

**Analysis and Explanation of the Decision include basis, findings, and conclusions used to support the decision:**

Per ODG, "Not recommended for X. However, X is recommended as an option for short-term pain relief in hip trochanteric bursitis." In this case, the hip Magnetic Resonance Imaging revealed X. There are no documented extenuating circumstances to support an exception to the guidelines. A was not medically necessary. Therefore, the request for the coverage of X is not medically necessary.

**A description, and the source of the screening criteria or other clinical basis used to make the decision:**

ODG-Official Disability Guidelines & Treatment Guidelines