

IRO Certificate No: X

## **Notice of Workers' Compensation Independent Review Decision**

X

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

X.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

X.

**PATIENT CLINICAL HISTORY [SUMMARY]:** This case involves a X with a history of an occupational claim from X and a request for X.

An x-ray of the left hip and pelvis dated X noted X.

On X, the patient was seen for a follow-up visit regarding chronic hip and pelvis pain. The patient reported worsening left sacroiliac pain. On exam, tenderness was noted X. It was noted that the patient was X. The treatment plan included a X.

A peer review report dated X noted that the records do not indicate the presence of a X

X.

A peer review report dated X noted that while the patient may have experienced functional benefit from the X.

A determination letter dated X indicated the denial of a request for X, as the request was determined too not be medically necessary.

On X, the patient was seen for a follow-up visit regarding left sacroiliac joint pain. It was noted that the patient previously responded very well to X. It was noted that the patient required X.

A peer review report dated X stated that the documentation does not support that the patient has an X.

A determination letter dated X indicated the denial of an appeal request for X, as the request did not meet established criteria for medical necessity and as such, the denial was upheld.

An independent review request dated X indicated that X was medically necessary due to the patient's X.

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

Official Disability Guidelines does not recommend X.

Guidelines indicate X are not recommended for non- X; however, X are recommended on a case-by- case basis as X. While the records indicate that the patient has previously benefitted from a X, the request for X is not medically appropriate. As such, the denial of X is partially overturned. X is medically necessary.

However, X is not medically necessary.

### **SOURCE OF REVIEW CRITERIA:**

- 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
- 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)

**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)