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Notice of Independent Review Decision

IRO Reviewer

Report X

IRO Case number: TX X

Description of the services in dispute

X

Description of the qualifications for each physician or 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

X, date of birth X, is a X individual diagnosed with pain in the left hip and seeking coverage for 1 Left Intra-Articular Sacroiliac Joint injection with Fluoroscopy performed under Anesthesia, with Minimal Sedation, as an outpatient.

The date of injury is X. The claimant's X. The claimant was diagnosed with a strain of muscle(s) and tendon(s) of the rotator cuff of the right shoulder; unspecified injury of muscle(s) and tendon(s) of the rotator cuff of right shoulder;

radiculopathy, lumbar region; pain in right shoulder; stiffness of the right shoulder, not elsewhere classified; a strain of unspecified muscle, fascia, and tendon at the shoulder and upper arm level, right arm; a strain of muscle, fascia, and tendon of the lower back; pain in left hip; a civilian activity done for income or pay; unspecified sprain of the right shoulder joint; pain in the right hip; adhesive capsulitis of the right shoulder; contusion of the left hip; sprain of ligaments of the lumbar spine; unspecified sprain of the left shoulder joint; incomplete rotator cuff tear or rupture of the right shoulder, not specified as traumatic; and other specific arthropathies, not elsewhere classified, right shoulder. Lumbar MRI dated X shows X. There was X. Severe X. A follow-up note with Dr. X dated X indicates that the claimant presents with left hip pain, which is rated X. The claimant was walking with an antalgic limp. The physical exam revealed the claimant X. The remainder of the exam was unremarkable. The treatment plan included an X. Other recommendations included X. On X, Dr. X submitted a Pre-Authorization Request for X. Due to X. A follow-up note dated X with Dr. X indicates that there was documentation of X. The physical exam revealed tenderness over the X. The remainder of the exam was unremarkable.

Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision

The request for X, is not recommended as medically necessary, and the previous denials are upheld. The initial request was non-certified noting that, "In this case, the patient is with nearly X. X continues to complain of LBP with BLE radiation. X's on gabapentin and duloxetine. X's on no tricyclic. There is severe foraminal stenosis at L5. X continues to complain of left buttock pain. There are no plain films of left hip, or MRI of left hip. X are not recommended unless the patient has a rheumatological disorder of the hip. Therefore, the request for X, as an outpatient is not medically necessary." The denial was upheld on appeal noting that, "in this case, the claimant reported X such pain. Moreover, monitored X would be excessive and unnecessary for a X. As such, the request for X is not medically necessary." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. Current evidence-based guidelines note that the requested X is not recommended for the treatment of X. It is noted that evidence shows inconclusive benefit, lack of benefit or potential harm. It is unclear what conservative treatment the patient has had for this region to date. There is no documentation of ongoing, concurrent active treatment modalities. As such, the request is not supported and not medically necessary.

Description and source of the screening criteria or other clinical basis used to make the decision

ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase

AHRQ - Agency for Healthcare Research and 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)