**Applied Resolutions LLC**
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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. Per a physical therapy plan of care by X, dated X, the treatment diagnosis was strain of muscle, fascia, and tendon of the posterior muscle group at thigh level, left thigh, initial encounter. X had been referred to X. At the time, X reported pain with increased activity and demonstrated tenderness to palpation, decreased active range of motion (AROM), decreased strength, decreased neuromuscular control, flexibility restrictions, impaired gait, and impaired proprioception. X had noticed balance issues, difficulty with stairs, squatting, kneeling, and walking. X would benefit from X. X prognosis was good. X. X, MD, evaluated X on X, for follow-up of X. X was seen on X, at which time, X was given a X. At the time, X presented for status check and reported X symptoms were unchanged by treatment. X described the pain as aching, constant, dull, sharp, tingling, stating it came randomly. X attended X. X took X. The pain level that day was X. On musculoskeletal examination, the left lower extremity revealed X. Dr. X noted the physical examination was consistent with X. X was discussed. X was denied by X Workers' Compensation. X had some increase in X neuropathy related to the sciatic irritation. Weaning the compression sleeve on the thigh at the time was discussed. They also discussed initiation of X. They discussed X and X was to follow-up with Dr. X in X weeks' time.

An MRI of the left femur dated X, identified X.

Treatment to date included X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "The Official Disability Guidelines (ODG) does not recommend the use of X. The ODG recommends X. In this case, X was injured on X and was found to have X. X to improve pain, motion, and strength. There is no documentation on extenuating circumstances to support up to X. There is also no documentation of an extenuating circumstance to support the request for X. As such, X. However, 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. Peer-to-peer was unsuccessful."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X. Rationale: "The Official Disability Guidelines (ODG) recommends up to X. Affiliated review X noncertified X was not agreed upon. In this circumstance, the claimant has been diagnosed with a left hamstring strain. On examination, they have an antalgic gait, tenderness of the posterior thigh, reduced knee motion, and weakness of the hip and knee. They have been recommended for X. While X is supported, there are no exceptional factors to X. As such, X. However, as I 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. Peer-to-peer was unsuccessful."

The requested X is not medically necessary. The submitted records do not support the need for X. Furthermore, the number of X being requested exceeds the associated guidelines and medical necessity. No new information has been provided which would overturn the previous denials. X are 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 X is not medically necessary. The submitted records do not support the need for X. Furthermore, the number of X being requested exceeds the associated guidelines and medical necessity. No new information has been provided which would overturn the previous denials. X are 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:**

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE