

C-IRO Inc.

Notice of Independent Review Decision

Case Number: X

Date of Notice: X; Amendment X

C-IRO Inc.

An Independent Review Organization

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Notice of Independent Review Decision

Amendment X

IRO REVIEWER REPORT

Date: X; Amendment 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)

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Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who sustained an injury on X. While attempting to X. The diagnoses included right hip pain, other low back pain, and sacroiliac joint somatic dysfunction.

X was seen by X, MD on X for a follow up of X right hip and groin pain as well as gluteal pain. X provided in the prior visit helped a little. X had been taking the X. X had been doing X. Pain was present mainly in the right anterior hip and groin. The pain was worse at night. It increased with physical activity. Body mass index was 28.5 kg/m². Right hip examination showed X. There was pain with resisted hip testing. Straight leg raise was X. X symptoms persisted despite X. It was thought that the X. The plan was for X.

An MRI of the lumbar spine on X showed X.

An MRI of the right hip dated X revealed X.

Treatment to date included X.

Per adverse determination by X, DO on X, the request for X was non-certified. Rationale: "The Official Disability Guidelines states that X is not recommended for hip osteoarthritis (OA) This treatment has been associated with X. X are recommended as an option for short-term pain relief in X. In this case, the patient reports right anterior hip pain, groin pain, and gluteal pain. They had pain and limitation with internal rotation and adduction, and pain with resisted hip testing. MRI of showed some X. Their symptoms persist despite attending X. The provider recommended a X. However, the records do not support findings consistent with X. In addition, the Guidelines indicate that X are not therapeutically helpful for hip osteoarthritis (OA), possibly accelerating OA progression. As such, the request for X is non-certified."

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Per Appeal Determination Denial by X, MD on X, the request for X was non-certified. Rationale: “The patient was seen on X by X, MD. The patient was seen for low back, right gluteal, and right hip pain resulting from a work injury involving X. The physician diagnosed multilevel lumbar degenerative disc disease, right hip joint effusion, and probable sacroiliac (ST) joint dysfunction. Treatment included X. The patient reported minimal improvement with these interventions. The physician recommended a X if symptoms persist. The patient has a X. Magnetic resonance imaging (MRI) reveals X. However, the ODG does not recommend a X. Therefore, the requested X is denied.”

The medical guidelines and subsequent medical literature do not support the use of X. No new information has been provided which would overturn the previous denials. X: X: 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 medical guidelines and subsequent medical literature do not support the use of X. No new information has been provided which would overturn the previous denials. X: X is not medically necessary and non-certified

Upheld

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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**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- 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**
- 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)**