

Clear Resolutions Inc.
Notice of Independent Review Decision
Clear Resolutions Inc.
An Independent Review Organization
3616 Far West Blvd Ste 117-501 CR
Austin, TX 78731
Phone: (512) 879-6370
Fax: (512) 572-0836
Email: @cri-iro.com

Notice of Independent Review Decision
Amendment X
Amendment X

IRO REVIEWER REPORT

Date: X; Amendment 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)

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 is a X who sustained an injury on X. X passed out in a X and broke X right ankle in 3 places. The diagnoses included unspecified sprain of left hip, strain of muscle of left hip, and pain in left hip joint. X was seen by X, MD on X for left hip pain. The provider believed that it was due to compensation for X right ankle fracture and shifting the pressure from an initial work related injury in X. X left hip pain was exacerbated with ambulating, stairs, rising from a seated position; improved with rest. No numbness or tingling was noted. X stated mild relief with a X, but X symptoms had returned. X reported some improvement from the X for the partial gluteus medius and minimus tears, but continued to have anterior hip pain from the labral tear. Body mass index was 26.6 kg/m². Left hip examination revealed tenderness to palpation over abductor. There was no crepitation or effusion. Active range of motion revealed flexion 120 degrees, external rotation 75 degrees, and internal rotation 30 degrees. Passive range of motion was not limited. Log roll was positive. Impingement sign was positive with 90 degrees flexion and internal rotation. There was no pain with resisted adduction or hemi-crunch. Reviewed x-rays of the pelvis and left hip showed no signs of fracture / dislocation, normal alignment, and moderate degenerative changes. Alpha angle was less than 50 degrees. No crossover sign. X was recommended. MRI of the left hip dated X showed acute grade 2 muscle strain of the left gluteus minimus muscle; tendinosis of the left gluteus medius and minimus tendons; tear of the anterior superior and posterior superior acetabular labrum; multilobulated cystic structure in the left adnexa measuring X in greatest dimension. X was recommended for further assessment. Treatment to date included X. Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: "The request for X is not warranted. The cited guidelines do not recommend the use of X for the treatment of muscle injuries and hip pain or disorders due to a lack of benefit and the risk of harm. An ultrasound guidance could be utilized. Although they have recurring left hip pain and tenderness on assessment, the said request is unsupported, as it is not an indicated method of treatment for the management of hip painful disorders due to unproven benefits and risk of harm. In addition, they were certified for X, which provided

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unspecified improvement. Hence, the prospective request for X is non-certified. “Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “Upon review of the submitted records and the peer-to-peer discussion, it appears that the prior noncertification was appropriate. The cited guidelines do not recommend the use of X due to a lack of benefit and the risk of harm. An ultrasound guidance could be utilized. Although they have recurring left hip pain and tenderness on assessment, the request is unsupported, as it is not an indicated method of treatment for the management of hip painful disorders due to unproven benefits and risk of harm. In addition, they were certified for an initial X, which provided unspecified improvement. Lastly, the provider did not provide any new information in regard to this request. A phone call to the requesting provider, X, M.D., at X was attempted at X in order to discuss the requested care. The provider was unavailable; however, a peer-to-peer discussion was completed with X, P.A., for Dr. X. The guideline recommendations for X were discussed. X states this X is for the labral tear and not the gluteus medius tear. Therefore, the appeal request for X is non-certified. “Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “The request for X is not warranted. The cited guidelines do not recommend X for the treatment of muscle injuries and hip pain or disorders due to a lack of benefit and the risk of harm. An ultrasound guidance could be utilized. Although they have recurring left hip pain and tenderness on assessment, the said request is unsupported, as it is not an indicated method of treatment for the management of hip painful disorders due to unproven benefits and risk of harm. In addition, they were certified for X, which provided unspecified improvement. Hence, the prospective request for X is non-certified.” Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “Upon review of the submitted records and the peer-to-peer discussion, it appears that the prior noncertification was appropriate. The cited guidelines do not recommend the use of X for the treatment of muscle injuries and hip pain or disorders due to a lack of benefit and the risk of harm. An ultrasound guidance could be utilized. Although they have recurring left hip pain and tenderness on assessment, the request is unsupported, as it is not an indicated method of treatment for the management of hip painful disorders due

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

Based on the clinical information provided, the request for X is not recommended as medically necessary and the previous denials are upheld. Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “The request for X is not warranted. The cited guidelines do not recommend the use of X for the treatment of muscle injuries and hip pain or disorders due to a lack of benefit and the risk of harm. An ultrasound guidance could be utilized. Although they have recurring left hip pain and tenderness on assessment, the said request is unsupported, as it is not an indicated method of treatment for the management of hip painful disorders due to unproven benefits and risk of harm. In addition, they were certified for X, which provided unspecified improvement. Hence, the prospective request for X is non-certified.” Per the utilization review by X, MD on X, the request for X was non-certified. Rationale: “Upon review of the submitted records and the peer-to-peer discussion, it appears that the prior noncertification was appropriate. The cited

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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)