

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: May 21, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OActive Knee Brace with Bionicare Knee Device. Three (3) months supplies. CPT Codes: L1844, L2810, L2820, L2830, L2780, L2397, E0762 and A9999.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Diplomate, American Board of Physical Medicine & Rehabilitation

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

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008
- 10/13/11, 11/28/11, 12/08/11, 01/12/12, 04/11/12
- 03/23/12
- Request for Authorization, 03/30/12
- 04/04/12, 04/20/12
- 04/16/12

Medical records from the Provider include:

- 08/19/11
- 09/28/11
- 10/13/11, 11/28/11, 12/08/11, 01/12/12, 03/22/12, 04/26/12
- 10/26/11

PATIENT CLINICAL HISTORY:

THE RECORDS AVAILABLE FOR REVIEW ARE LESS THAN ADEQUATE OR SPECIFIC IN REGARD TO IDENTIFICATION OF HISTORY OF PREVIOUS AND PRESENT INJURY, TREATMENT OR POST SURGICAL REHABILITATION. **There are 1.5 inches of prefabricated template notes/forms filled out by xxxxxx, M.D.** The format of notes presented provides minimal information outside of numerous checked boxes. Consequently, I am forced to presume the following:

The patient injured her left knee at some point performing work related activities. The patient had definitive left knee surgery in the form of arthroscopic intervention on November 28, 2011.

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

There is no need for any additional treatment since definitive care has been provided as described above.

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
- AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)