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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. X was working on X. X stated X miles per hour winds picked up X heavy panels estimated to be around X pounds which struck X calf causing X to twist X knee. The diagnosis was pain in right knee, contusion of right knee, other tear of medial meniscus, current injury of right knee; other internal derangements of right knee, and displaced fracture of right tibial spine. On X, X, MD evaluated X for chief complaint of right knee pain. X returned for a follow-up of X right knee pain. X was last seen on X at which time, potential surgical intervention was discussed. X had the surgery approved through Workers' Compensation. X symptoms were stable from prior visit. On examination of right knee, there was X. There was X. Range of motion was X degrees. The MRI findings revealed X. X was recommended to proceed with surgical intervention which X. Also a X was recommended. An MRI of right knee dated X revealed X. Treatment to date included medications. Per a peer review dated X by X, MD, the request for X is denied. Rationale: "Per medical literature, reports of X. We present an all-X. Per ODG guidelines conditionally recommended as indicated below. However, there is no imaging documented for review along with failed treatments. There needs to be noted nonoperative care prior to surgical intervention. Therefore, the request for X is non-certified. "Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The requested procedure is non-certified. Therefore, the request for X is non-certified. "On X, an appeal request was provided for X. Per a peer review and reconsideration / utilization review adverse determination letter dated X by X, MD, the appeal request for X was denied. This is an appeal to review X. Rationale:

“The requested X is not medically necessary. The guidelines do not support the X. As such, the guidelines have not been met. Therefore, the appeal request for X is non-certified. “Per a utilization review adverse determination letter dated X, the request for X. This is an appeal to review X. Rationale: “The appeal request for X is certified. “Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. The initial request was non-certified noting that, “Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “The requested procedure is non-certified. Therefore, the request for X is non-certified.” The denial was upheld on appeal noting that, “Per a peer review and reconsideration / utilization review adverse determination letter dated X by X, MD, the appeal request for X was denied. This is an appeal to review X. Rationale: “The requested X is not medically necessary. The guidelines do not support the use of a X. As such, the guidelines have not been met. Therefore, the appeal request for X is non-certified.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient has been authorized for X. Guidelines note that X. Guidelines state that X. There is no documentation of X. Therefore, medical necessity is not established in accordance with current evidence based guidelines. 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:

Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. The initial request was non-certified noting that, “Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “The requested procedure is non-

certified. Therefore, the request for X is non-certified." The denial was upheld on appeal noting that, "Per a peer review and reconsideration / utilization review adverse determination letter dated X by X, MD, the appeal request for X was denied. This is an appeal to review X. Rationale: "The requested X is not medically necessary. The guidelines do not support X. As such, the guidelines have not been met. Therefore, the appeal request for X is non-certified." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient has been authorized for X. Guidelines note that X. Guidelines state that X. There is no documentation of X. Therefore, medical necessity is not established in accordance with current evidence based guidelines. X is 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:

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

☐ 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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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

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

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL