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Notice of Independent Review Decision
Amendment X
Amendment X

IRO REVIEWER REPORT

Date:X; AmendmentX; 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 Overtuned 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 X. The diagnosis was medial meniscaI tear with degenerative changes of right knee. On X, X was seen by X, MD for right knee pain. X attended X. X had X. Right knee examination showed pain X. There was X. X caused pain. X was recommended. An MRI of the right knee dated X demonstrated X. X of the right knee which was moderate to severe within the medial compartment. There was marked X. X was noted. X could be secondary to degeneration of the ligament or a mild sprain. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X is non certified. Rationale: "The request for X is not medically necessary. The injured worker has X. ODG does not support X with these findings. "Per a reconsideration review adverse determination letter dated X by X, MD the appeal request for X is non certified. Rationale: "The injured worker in this case has X. There is evidence of an X on MRI. X in this clinical picture is not warranted and not supported by ODG. X is not medically necessary." The requested X is not medically necessary. The submitted records demonstrate the presence of X. The records reflect that the patient has attended X. The guidelines do not support for 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 requested X is not medically necessary. The submitted records demonstrate the presence of X. The records reflect that the patient has attended X. The guidelines do not support for X. 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**
- ☐ **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)**