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Notice of Independent Review Decision

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 Overtuned 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X stated that at work while X. The diagnosis was sprain of left ankle, tear of medial meniscus of knee, left and derangement of left knee. On X was seen by X, MD for follow-up of left knee pain. On the prior visit dated X, X returned with continued moderate knee pain, swelling, occasionally locking, left-sided tenderness greater than medial tenderness. X was in therapy but not making significant progress. At the time, Dr. X wrote, “once again this will serve as a letter for reconsideration patient has X.” X additionally reported left hip pain, left ankle pain, and left knee pain. X rated the pain as X. On examination, X was noted to be in mild distress secondary to issues associated with the left lower extremity. The main complaint was left knee pain, also left ankle pain and swelling. X had difficulties at the time ambulating and was using crutches. Examination of the knee was guarded and examination of the ankle showed X. The left knee examination was unchanged, and X was still with a X. The assessment was sprain X. An X of the left knee dated X showed X. Left ankle MRI results were discussed with X. An X was re-ordered. X was counseled on eating healthy foods and maintaining a healthy lifestyle. An X dated. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied as not medically necessary. Rationale: ““ODG by MCG Last review/update date: X: Diagnostic Testing, X. X is experimental and therefore not recommended." “The patient is having ongoing symptoms including locking following meniscectomy. There has been no new trauma. The cited guidelines do not allow for X. The patient does not appear to have had X. The request for X is not medically necessary. Therefore, the request for X is non-certified.” In the office visit note dated X, Dr. X wrote, “Once again this will serve as a letter for

reconsideration. Patient has X. We have tried to obtain an X has been denied by carrier twice. One of the reasons for denial was X has been done. We did an X today." Per a reconsideration review adverse determination letter dated X by X, MD, the appeal request for X was denied. Rationale: "Non-traumatic knee pain (adult), non-localized pain, initial knee radiographs are negative or demonstrate a joint effusion" In this case, the patient has complaints of left knee pain. An X is requested. However, there is no documentation that X. Therefore, the request is not certified." The requested X is not medically necessary. The patient continues to report X on X. There is reported post-surgical physical therapy but no documentation of such has been submitted for review to document failure. An x-ray of the left knee does not demonstrate any acute osseous abnormalities. No new information has been submitted which would overturn the previous denials. 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:

NA

The requested X is not medically necessary. The patient continues to report left knee pain after undergoing a left knee arthroscopy with medial and lateral menisectomies on X. There is reported post-surgical physical therapy but no documentation of such has been submitted for review to document failure. An X. No new information has been submitted which would overturn the previous denials. 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**
- ☐ **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)**