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***Notice of Independent Review Decision
Amendment***

IRO REVIEWER REPORT

X; Amendment

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTX
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:

Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW: X

PATIENT CLINICAL HISTORY [SUMMARY]: X is a X who was injured on X. X was X. The diagnosis was medial meniscal tear with degenerative changes of right knee. On X, X was seen by X, MD for right knee pain. X attended three sessions of X. X had severe X. Right knee examination showed pain over the medial joint line. There was no effusion. 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 of the distal segment of the X. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the 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 consisting of X is not medically necessary. The submitted records demonstrate the presence of X. The records reflect that the patient has attended X and undergone X. The guidelines do not support for X with severe 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 consisting of X is not medically necessary. The submitted records demonstrate the presence of X. The records reflect that the patient has X and undergone X. The guidelines do not support for X with severe X. X is not medically necessary and non certified

Upheld

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTX
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)**
- OTX EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED
GUIDELINES (PROVIDE A DESCRIPTION)**