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Notice of Independent Review Decision
Amendment X

IRO REVIEWER REPORT

Date: X; 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, X who was injured on X. X. The diagnosis was sprain of left knee and tear of medial meniscus of left knee. On X, X presented to X, MD for a Workers' Compensation follow-up. X was seen for re-evaluation of a left knee strain with resultant medial meniscus tear and root tear. Until that time, X had been treated extensively with X. X had continued to experience painful mechanical symptoms. Dr. X had recommended an X but it had been denied twice. X presented at the time with complaints of persistent painful catching and locking of the knee. X had difficulty at the end of the day with weightbearing activities. X presented to discuss treatment options. Vitals showed a blood pressure of 122/80 mmHg, a BMI of 46.1 kg/m2, and a pain score of X. Examination of X left knee continued to show X. X was X. X. X had X. The assessment was X. Dr. X noted X was young and active and had X. X continued to experience X. Unfortunately, X request for X. At the time, X was obviously in some discomfort and Dr. X thought this could give X some relief. X was to follow-up in X weeks. If X mechanical symptoms persisted, Dr. X recommended X go through an appeal process to see if X could have X approved. On X, X visited X, NP for re-evaluation of X work-related left knee strain. Per the note, MRI of the left knee provided diagnosis of medial meniscus tear. X continued to have significant painful mechanical instability, locking, and catching. X was unable to complete X routine activities of daily living or sleep throughout the night. X had X. Examination of X left knee continued to X. X was X. X. X had a X. X had X. X noted that X continued to be significantly symptomatic with X work-related left knee injury resulting in a X. X quality of life was compromised as X was unable to complete even basic activities of daily living or sleep throughout the night. X had

trialed and X. With X recalcitrant pain and worsening painful instability, it was still recommended that X. During the previous visit with surgeon Dr.X , the possibility of going through an appeal process was discussed, and this was decided at the time. X would obtain directions on this process. For the time being, they would maintain X same restrictions and follow-up in X weeks to discuss the next steps. An MRI of the left knee dated X identified complex tear of the medial meniscal posterior root with mild subjacent tibial bone marrow edema. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “Based on the documentation provided, the claimant has been recommended for X. The claimant is a X that was injured on X. The claimant was injured when X. On X, the claimant presented to X, MD. The claimant continued to report difficulty with going up and down the stairs. The pain was posterior and recurred with deep flexion and bending. The claimant has been treated with X. Examination of the left knee revealed continued X. The X was X. There was X. The claimant has had X. The claimant was noted to have had an X. Therefore, medical necessity cannot be established for X. “Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: “Per the Official Disability Guidelines X. Not recommended for osteoarthritis (OA) in the absence of major mechanical locking or for older patients with degenerative meniscus tears who are more appropriately treated with physical therapy/exercise. Criteria for X. The claimant reported significant improvement in left knee pain with difficulty going up and down stairs and pain in the back of the knee with deep flexion and bending. There was X. There was X. However, the claimant reported an X. As such, the medical necessity has not been established for X. The requested surgical procedure is medically appropriate and necessary. The medical records I do demonstrate that the patient reports mechanical symptoms of locking and catching. The patient has completed a course of X. The imaging report does

demonstrate a meniscal tear. The patient has completed an appropriate course of X. As such, the requested surgery has met medical necessity. X is medically necessary and certified

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

The requested surgical procedure is medically appropriate and necessary. The medical records I do demonstrate that the patient reports mechanical symptoms of locking and catching. The patient has completed a X. The imaging report does demonstrate a meniscal tear. The patient has completed an appropriate course of X. As such, the requested surgery has met medical necessity. X is medically necessary and certified

Overturned

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)**