Becket Systems
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Notice of Independent Review Decision

Sent to the Following

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 Overtuned (Agree in part/Disagree in part)

☒ Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who sustained an injury on X. Per the prior review, the mechanism of injury was identified as an X. The diagnoses included chondromalacia of medial femoral condyle, right; status post chondroabrasion, chondroplasty, synovectomy; other specified disorders of synovium, right knee; status post chondroabrasion, chondroplasty, synovectomy; chondromalacla of right knee; status post chondroabraslon, chondroplasty, synovectomy; and complex tear of medial meniscus as current injury, left, initial encounter.

X was seen by X, PA-C / X, MD on X for left knee pain. X reported that X continued to have severe pain in the left knee even with X. X stated there had been no improvement even X. X reported that the pain had not changed since X initial WC injury. X stated that X was having the same pain on the other knee and the arthroscopic knee scope almost completely resolved symptoms. X was having issues continuing with exercises due to pain. X reported that the right knee was feeling better after X knee scope. X was X. Right knee examination revealed X. Portal sites were healed well without significant X. X revealed X. There was no X. Strength was X consistent with contralateral side. Left knee examination revealed X. Active flexion and extension were full with pain at X. X was X. X gait was X. X was using a X. Per the note, undated x-rays of the left knee showed X. MRI of the left knee revealed X. X was is not symptomatic to patella.

Treatment to date included X.

Per the Adverse Determination Notice by X, MD on X, the request for X was non-certified. Rationale: “No, the proposed treatment consisting X is not appropriate and medically necessary for this diagnosis and clinical

findings. The Official Disability Guidelines recommend X. The claimant has chronic left knee pain with objective findings noted. The claimant also X. However, the Imaging cited a X. Thus, the request for X is noncertified."

Per the Adverse Determination After Reconsideration Notice by X, MD on X, the request for X was non-certified. Rationale: "No, the proposed treatment consisting of X is not appropriate and medically necessary for this diagnosis and clinical findings. Official Disability Guidelines recommends surgical repair of meniscal tears. On X, the claimant was seen for severe pain of left knee. Left knee exam shows X. As such, the request for X is noncertified."

The surgical procedure consisting of a X is not medically necessary. The records reflect that the patient has chronic knee pain. The MRI report does not demonstrate a X. No new information has been provided 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:

The surgical procedure consisting of a X is not medically necessary. The records reflect that the patient has chronic knee pain. The MRI report does not demonstrate a X. No new information has been provided which would overturn the previous denials. X is not medically necessary and non certified

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)**