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Notice of Independent Review Decision

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 Overturned Agree in part/Disagree in part

☒ Upheld Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

• X

PATIENT CLINICAL HISTORY [SUMMARY]:

X with a date of injury X. The biomechanics of the injury was not available in the medical records. The diagnosis was unilateral primary osteoarthritis, right knee (X).X was seen by X, PA / X, MD on X. X presented for a X into the right knee and an X into the left knee. X had noticed some improvement. On examination, X was ambulating normally. Examination of the right knee showed full motion, no effusion, and tenderness to palpation over the medial joint line. A right knee X was performed without complications. The diagnosis was unilateral primary osteoarthritis of the right knee. They would attempt to authorize a X to be done in the next few weeks. Per a DWC Form-X by Dr. X, X could return to work with the restrictions, which were expected to last through X. Dr. X requested a X. A CT scan of the right knee dated X revealed intact X. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X and peer review dated X, the request for X was denied by X, MD. Rationale: "No, the services requested X. X are not medically necessary. In this case, the claimant has complaints of continued right knee pain and X. Exam of the right knee revealed tenderness to X. However, there was no recent imaging study provided to confirm osteoarthritis. Additionally, the claimant has had a previous X is not documented. Therefore, medical necessity has not been established. "Per an adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: "The patient was diagnosed with unilateral primary osteoarthritis, in the right knee. The cited guidelines support the request for X. The request is not

medically necessary and appropriate as the provider was not reached to modify the request. As such, the requested X. X is denied. “Based on the submitted medical records, the requested X is not medically necessary. The guidelines and medical literature do not support the use of X. No new information has been provided which would overturn the previous denials. X as requested by X, M.D. is not medically necessary and non certified

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

Based on the submitted medical records, the requested X is not medically necessary. The guidelines and medical literature do not support the use of X. No new information has been provided which would overturn the previous denials. X as requested by X, M.D. 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

☐ 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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL