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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)

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 was a X. This did not cause X to fall but X had bruising and swelling to the knee afterwards. The diagnosis was left knee pain. An Orthopedic Clinic Note dated X, by X, MD, was documented. X presented for evaluation of the left knee, with a chief complaint of left knee injury. X was a X. This did not cause X to fall but X had bruising and swelling to the knee afterwards. X was initially evaluated at an urgent care. X had persistent knee pain since the accident. X localized the pain predominantly beneath the kneecap. It started out on the medial side and X had some lateral side pain with this as well. X described it as a constant ache. X did not have any pain with bending. X did note that the knee hurt worse towards the end of a long day. X denied any instability or giving out of X leg. X had no mechanical locking symptoms. X endorsed occasional popping with knee flexion. X had been able to continue X work as a X. X tried taking X. X had not done any X. X described the left knee pain as aching, continuous, and ongoing and rated it an X. X stated it was gradually worsening. Aggravating factors included bending, stretching, straightening, exercise, squatting, standing, walking, and stairs. On musculoskeletal examination, the left lower extremity identified X. X had some mild tenderness along the medial knee. X range of motion was from X. X knee was stable to varus and valgus stress at X and X degrees. Anterior-posterior drawer testing was X. X did

have a X. Motor and sensation were X. Dr. X reviewed imaging studies. X-rays of the left knee demonstrated X. The left knee MRI showed X. X were all X. X did have a X. The X appeared X. The X were also X. There was a X. The assessment was left knee pain. Dr. X assessed that X had an MRI finding consistent with a X. The remainder of the knee was unremarkable. Based on X exam and imaging, Dr. X thought that X. X thought X would benefit from a X. At the time, there was no obvious indication for X. It was very likely that the X. X knee was stable and had no evidence of X. X could return to full duty. X should take the elevator when able but could climb stairs as needed. Dr. X encouraged X to work on X. A handout was provided. X would need preauthorization as this was a Workers' Compensation injury, but they would proceed with a X as soon as that was approved. Dr. X thought X would benefit from X. The risks and benefits of the medication were discussed. X-rays of the left knee done on X, for left knee pain, revealed X. Treatment to date included X, Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. 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 is a X, and X was injured when X. On X, the claimant presented to X, MD with complaints of left knee pain. The claimant localized the pain predominantly beneath the kneecap and described it as a constant ache. The claimant noted that the knee hurt worse towards the end of the day and endorsed an occasional popping with flexion. The pain was rated X, gradually worsening, and was aggravated with bending, stretching, straightening, exercise,

squatting, standing, walking, and stairs. Examination of the left knee revealed X, In this case, there is no evidence the claimant has completed X. Medical necessity cannot be established for X. “Per a reconsideration review adverse determination letter dated X, X, MD, nonauthorized reconsideration for X as not medically necessary. Rationale: “X. X is not yet recommended pending further study. X is contraindicated following X. A peer review with the treating provider did occur. The patient was diagnosed with pain in the left knee, sprain of the unspecified site of the left knee, contusion of the left knee, and other internal derangements of the unspecified knee. The treating provider stated that the patient has been taking X. The provider confirmed that there is no presence of X. The provider confirmed that the purpose of the X. The provider confirmed that the patient has not attempted a X. As such, the guidelines have not been met for the requested X. Therefore, the request for X is non-authorized. “Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. 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 is a X, and X was injured when X. On X, the claimant presented to X, MD with complaints of left knee pain. The claimant localized the pain predominantly beneath the kneecap and described it as a constant ache. The claimant noted that the knee hurt worse towards the end of the day and endorsed an occasional popping with flexion. The pain

was rated X, gradually worsening, and was aggravated with bending, stretching, straightening, exercise, squatting, standing, walking, and stairs. Examination of the left knee revealed X; range of motion was from X; mildly positive grind; intermittent popping appreciated which was minimally painful and reproducible, In this case, there is no evidence the claimant has X. Medical necessity cannot be established for X." Per a reconsideration review adverse determination letter dated X, X, MD, nonauthorized reconsideration for X as not medically necessary. Rationale: "ODG by MCG Knee and Leg (Updated: X) X. However, due to time- and dose-related X. X is contraindicated following X. A peer review with the treating provider did occur. The patient was diagnosed with pain in the left knee, sprain of the unspecified site of the left knee, contusion of the left knee, and other internal derangements of the unspecified knee. The treating provider stated that the patient has been X. The provider confirmed that there is X. The provider confirmed that the purpose of the X. The provider confirmed that the patient has not attempted a X. As such, the guidelines have not been met for the requested X. Therefore, the request for X is non-authorized." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. X-rays of the left knee show the X. X has X. The submitted clinical records fail to establish the presence of X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. 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:

Based on the clinical information provided, the request for X is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. 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 is a X, and X was injured when X. On X, the claimant presented to X, MD with complaints of left knee pain. The claimant localized the pain predominantly beneath the kneecap and described it as a constant ache. The claimant noted that the knee hurt worse towards the end of the day and endorsed an occasional popping with flexion. The pain was rated X, gradually worsening, and was aggravated with bending, stretching, straightening, exercise, squatting, standing, walking, and stairs. Examination of the left knee revealed X; X, in this case, there is no evidence the claimant has X. Medical necessity cannot be established for X.” Per a reconsideration review adverse determination letter dated X, X, MD, nonauthorized reconsideration for X as not medically necessary. Rationale: “ODG by MCG Knee and Leg (Updated: X) X. However, due to time- and dose-related X. X is not yet recommended pending further study. X is contraindicated following X. A peer review with the treating provider did occur. The patient was diagnosed with pain in the left knee, sprain of the unspecified site of the left knee, contusion of the left knee, and other

internal derangements of the unspecified knee. The treating provider stated that the patient has X. The provider confirmed that there is X. The provider confirmed that the purpose of the X. The provider confirmed that the patient has X. As such, the guidelines have not been met for the requested X. Therefore, the request for X is non-authorized." There is insufficient information to support a change in determination, and the previous non-certifications are upheld. X-rays of the left knee showX. X has not X. The submitted clinical records fail to establish the presence of X. Therefore, medical necessity is not established in accordance with current evidence-based guidelines. 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**
- ☐ **TMF SCREENING CRITERIA MANUAL**

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

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