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IRO Certificate #X

Notice of Independent Review Decision

DATE OF REVIEW: X

IRO CASE NO. 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:

Upheld (Agree) X

Overtured (Disagree)

Partially Overtured (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY SUMMARY

Patient, X, has been denied request for X, as being medically unnecessary.

Patient's DOI, X; mechanism is not documented. Adverse Determination Letter, X, states patient was diagnosed with chronic pain and stiffness of the right knee. X has a X. Also noted there was an occupational claim in X. It states X underwent X. With X history of right knee pain patient is requesting X. The requested procedure was non-certified as being not appropriate and not medically necessary as it did not meet ODG for X.

Appeal/Reconsideration Letter dated X, by Dr. X, also non-certified the request for authorization for X. Dr. X felt the procedure was not medically necessary and that the X, dated X, did not show sufficient evidence of failure of the device.

Clinic note, dated X, from the office of Dr. X, noted patient's previous procedures on the right knee. X history of reports that the patient presents for right knee pain reveal stiffness and giving way. Pain worse with activity. X has X. X has difficulty extending the knee and pain at night; denies any fever chills or night sweats. There was history of X. Patient states X has not done any X. X reports difficulty with the ADL's. Exam shows X's in no apparent stress, well nourished, and obese. Right knee shows well healed incision, no erythema, swelling or effusion, alignment neutral, ROM X to X degrees. X does have pain or crepitus with ROM, tenderness over medial joint line. X has normal muscle strength, stability to A/P stress, M/L stress, firm

PATIENT CLINICAL HISTORY SUMMARY (continuation)

endpoints, normal pulses. Note documents X of right knee X views, Lateral and Sunrise views revealing a X. X is noted along the anterior and posterior aspect of the femoral component. **Note recommends X.**

Clinic note dated X from Dr. X reports that **patient returns with elevated CRP and ESR.** I do not have the actual values available for review and they are not in the note. X reports that

symptoms are unchanged. Exam shows well healed incision, tenderness medially and laterally, no instability. Patient underwent X. Note states that infection would need to be ruled out. Patient is to take X.

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

Opinion: I agree with the benefit company's decision to deny the requested service.

Rationale: X and exam are not consistent with failure of the device or chronic instability. There is also insufficient evidence to confirm septic arthritis in the knee. **The requested service, X, is not appropriate or medically necessary.**

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE &

**EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL
STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE
GUIDELINES

MILLIMAN CARE GUIDELINES

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT
GUIDELINES X**

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY
ASSURANCE & PRACTICE PARAMETERS

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL
LITERATURE (PROVIDE DESCRIPTION)

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