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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 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 injured in a work-related incident. X stated that while working for X, X injured while performing X normal work duties at X normal capacity. X stated that because of work injury, X sustained injuries to X right knee regions caused by X. X fell backwards and to the left, X right foot was planted, and the knee twisted. X felt a pop when X tried to straighten the knee and felt immediate pain. The diagnosis was strain of other muscle(s) and tendon(s) at lower leg level, right leg, initial encounter and unspecified internal derangement of right knee. On X, X, DC evaluated X for a re-examination. X complained of pain in X right knee, and X reported difficulty with household chores and weight bearing. X stated that X was taking the recommended medications, which helped X perform X ADLs, at least temporarily. X stated X completed X. X was not at Full duty. Dr. X completed surgery on X. X was advised to continue "X". X stated that X was not using the brace. Dr. X was recommending MRI and was recommending wearing the brace again. X was ordered due to continued pain. Right knee surgery was performed X. X had a follow-up with Dr. X, cleared for X. X was taking X. X was completing X. X had X. X had seen Dr. X, and X was recommended to X. X reported a pain level of X. X was completing X. X reported having pain and swelling in X lateral right knee. X knee was drained by Dr. X and X. X continued to have X. X anti-inflammatory medications were changed. New medications from Dr. X helped with inflammation. X had a follow-up with Dr. X the day before the visit and was recommended X. On examination, X weight was 397 pounds. X X were antalgic with a visual limp. Right knee palpation revealed X. Orthopedic examination was deferred due to recent surgery. X had restricted range of motion in flexion. The right X was improved. There was X. X was recommended to X. Treatment to date has included

X. Per a utilization review adverse determination letter dated X by X, DC, the request for X was denied. Rationale: “The X request does not meet Official Disability Guidelines (ODG) by MCG criteria, and it exceeds the recommendations of the ODG. The claimant has already completed X. Fading of treatment frequency and active self-directed supervised home X are not properly documented. There is no supporting documentation indicating that the claimant would benefit from X. X has already X. Therefore, the requested X is not medically necessary. “Per a reconsideration / utilization review adverse determination letter dated X, by X, DC, the request for X was denied. Rationale: “In this case, the patient is a X who was injured in a work-related incident on X. A peer conversation did not take place. Based on the records reviewed, the X. The exact number of X. Without speaking with the treating provider to verify how much X. Based on the guidelines, the medical necessity for this request has not been met. As such, the appeal is upheld.
“Thoroughly reviewed provided records including peer reviews. Patient has X, but the X was on X. X in this timeframe may be indicated were the patient to have had some X. 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:

Thoroughly reviewed provided records including peer reviews. Patient has X but the X was on X. X in this timeframe may be indicated were the patient to have had some X. 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)**