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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 is a X who was injured on X. The mechanism of injury was documented as slipping / tripping injury. The diagnosis was osteoarthritis of bilateral knees. X was evaluated by X, MD for follow-up of osteoarthritis of the right knee joint. X returned at the time for X. Examination of the right knee showed a X. X had pain with X. X also had a X. Active ROM showed X degrees flexion. Examination of the left knee showed a X. Active ROM measured X degrees of flexion. X were performed. The assessment was osteoarthritis of right knee and bilateral osteoarthritis of knees. On X, X was seen by Dr. X for follow-up of bilateral osteoarthritis of the knees. X returned with increased pain and swelling in X right knee. X stated, the past weekend, X was walking when X felt a strong pop in X knee. X stated it caused X to stop in X tracks, but after a few minutes, it felt like something released, and the knee felt better. X stated the knee was feeling good for a few days and then the same thing happened the previous day. X stated it was not as severe, but X had noticed increased swelling in the knee since then. The right knee examination revealed a X. X was performed. The assessment was bilateral osteoarthritis of knees, pain of right knee joint, and effusion of right knee joint. X-rays done that day showed X. Treatment to date included X. Per a utilization review adverse determination letter dated X and a peer review dated X, the request for X was denied by X, DO. Rationale for X for the right knee: “X is not medically necessary. Based on the documentation provided and the guidelines, the requested X is not supported. Although the claimant continues to have pain secondary to work-related injury, there was a lack of any documented functional improvement with X. Therefore, X is not medically necessary.” Rationale for X for the left knee: “X is not medically necessary. Based on the documentation provided and the

guidelines, the requested X is not supported. Although the claimant continues to have pain secondary to work-related injury, there was a lack of any documented functional improvement with X. Therefore, X is not medically necessary. “Per a reconsideration review adverse determination letter dated X and a peer review dated X, the appeal request for X was denied by X, MD. Rationale for X: The request is not medically necessary. The claimant had X on X. ODG supports X. This criteria has not been met. Therefore, the request is not medically necessary. “Based on the submitted medical records, the requested X are not medically necessary. There is no documentation of improvement from X. No new information was provided to 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:

Based on the submitted medical records, the requested X are not medically necessary. There is no documentation of improvement from X. No new information was provided to overturn the previous denials. 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)**