Applied Resolutions LLC
An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #790
Mansfield, TX 76063
Phone: (817) 405-3524
Fax: (888) 567-5355
Email: @appliedresolutionstx.com

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 who was injured on X. X was injured while X. The diagnosis was acute left medial meniscus tear. On X, X was seen by X, MD for following up for "X" and follow up X. X was previously seen on X, at which time counselling obesity was performed. Since then, X stated the X was stable. X was also following up for X. X was seen on X, at which time X received X. Date of surgery was X. X was treated with X was performed. That day, X reported pain was radiating and lasting throughout the day. Pain was described as sharp. Pain worsened with activity. X followed the treatment plan as directed. Examination showed X. Strength in left knee was X. Strength in left hamstring was X. Left knee was X. Apley's grind test and McMurray test were X. Tenderness was noted at X. Left knee MRI dated X was reviewed which showed X. Otherwise, X was seen. X was recommended to apply ice, compression, give rest and elevate X affected extremity. X was recommended to X. Obesity counseling was done. An MRI of the "left" knee dated X showed X. X was noted in the X. Otherwise X was seen. Treatment to date included X Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "There is a treatment plan for revising the X for this claimant. The Official Disability Guidelines support a X. MRI study for this claimant's knee dated X notes X. Additionally, this claimant has X. Absent these subjective complaints and objective findings of arthritis, this request for X is not supported and recommended for noncertification. "Per a reconsideration review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "The ODG recommends X. They have attended X. They report knee pain and

instability. On exam, there is X. An MRI on X documented a X. The provider has requested X. Given the recurrent X. However, there are no exceptional factors to support other indicated procedures. As such, partial certification is recommended with certification for X. However, as I was unable to reach the treating physician to discuss treatment modification, the request remains not certified at this time. “The requested X is not medically necessary. The submitted documentation indicates that the claimant has X. It does not appear that the claimant has undergone appropriate conservative treatment as outlined by the guidelines. Furthermore, the rationale for indicated procedures is not so supported during the requested 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:

The requested X is not medically necessary. The submitted documentation indicates that the claimant has underlying X. It does not appear that the claimant has undergone appropriate conservative treatment as outlined by the guidelines. Furthermore, the rationale for indicated procedures is not so supported during the requested 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

☐ 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