

**Core 400 LLC**  
**An Independent Review Organization**  
**3616 Far West Blvd Ste 117-501 C4**  
**Austin, TX 78731**  
**Phone: (512) 772-2865**  
**Fax: (512) 551-0630**  
**Email: [@core400.com](mailto:@core400.com)**

***Notice of Independent Review Decision***

**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 Overturned (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. X was injured as a result of X. The assessment included pain of X. X presented to X, MD on X for right knee pain. The pain occurred intermittently and was aching, burning, dull, radiating, stabbing associated with throbbing and worsening. In addition, X rated X pain X. The pain was associated with weakness and the knee giving way. X had been treated with a X. X reported difficulty with activities of daily living and tenderness, weakness, extremity numbness, limping, difficulty sleeping, decreased mobility, nocturnal awakening and weakness. Examination showed X. Right knee showed X. Apley grind test and McMurray test was X. X was recommended to X. On X, X was seen by Dr. X for right knee pain. X was following up after completing X of X right knee. X continued to have pain and discomfort and had X. On examination X weight was 360 pounds and body mass index (BMI) 50.2 kg/m<sup>2</sup>. The right knee examination showed X. The X was noted. McMurray's test was X. The plan was to proceed with X. Per a letter of medical necessity dated X, Dr. X stated, "This is a letter of medical necessity for X. X injured X right knee which X was at work on X. When X came in the office to be evaluated. I was worried that X may have a X. X-rays performed in the office showed X. X arthritis is more involved in the X. I do feel that this X is causing the pain that brought X in to be evaluated even though X does have some signs of arthritis. X only has moderate X. Therefore, I do think it is medically necessary to X. "An MRI of the right knee dated X revealed X. "X" with moderate X was noted. X was noted. No X was noted. Treatment to date included X. Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Per the ODG by MCG, X is recommended as indicated by the guidelines for X. X is usually contraindicated with any imaging presence of osteoarthritis (OA) and/or degenerative tears. Obesity also suggests poorer outcomes. Based on the clinical findings and imaging report, the claimant does not meet the guideline's criteria for the requested surgery. As such, the request is non-certified. "Per a reconsideration review adverse determination letter dated X by X, MD the request for X was denied. Rationale: "Per ODG guidelines for X. "It is recommended, as indicated below, for X. It is not recommended for X. Whether

or not X is performed, X increase the risk of subsequently developing X." The patient was diagnosed with another tear of the medial meniscus and a current injury of the right knee. Based on the provided documentation, the patient has left knee pain. Physical examination of the left knee revealed tenderness of the medial joint line. Swelling and effusion were noted. There was a X McMurray's test. The patient reported muscle aches and joint pain. A Magnetic Resonance Imaging (MRI) of the left knee taken on X revealed a X. The patient has tried X. The patient also has a X. However, X, and no major mechanical locking was noted on examination. The criteria have not been met. Therefore, the request is not medically necessary. As such, the requested is denied. "The requested surgical procedure is not medically necessary based on the submitted documentation. The submitted imaging reports indicate the presence of X. There were no significant examination findings to suggest the presence of mechanical locking. In addition, the patient was morbidly obese with a BMI of 50.2 kg/meters<sup>2</sup>. No new information was provided which would 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:**

The requested X is not medically necessary based on the submitted documentation. The submitted imaging reports indicate the presence of X. There was no significant examination findings to suggest the presence of mechanical locking. In addition, the patient was morbidly obese with a BMI of 50.2 kg/meters<sup>2</sup>. No new information was provided which would 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)**