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**An Independent Review Organization**  
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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 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. fell because of black ice, with X knee twisting unusually behind X when first fell. tried to get up and fell immediately again and then crawled to where got some support and was able to hold X up and then walked off with support. The diagnosis was sprain of unspecified site of left knee.

X was seen by X, MD on X for X ongoing complaints. reported left shoulder symptoms were unchanged. was seeing Dr. X about X ankle. At X request, was sent for an impairment rating, which was performed by Dr. X on "X." Dr. X did not feel X was at MMI, so no impairment rating was not given, and Dr. X concurred with the opinion. X reported had previously even fallen because X left knee gave out on X and injured the lip and the tooth, for which a procedure had to be done including root canal. X left knee meniscus pathology had finally been accepted by workers' compensation and stated X knee was feeling better to X following X performed on X than it was before. was trying to get them to accept X. had obtained a shoulder harness type brace which found helped X shoulder symptoms somewhat. started

therapy for X knee post-surgery on X was delayed and only began in mid-X. stated had been going twice weekly and was finding it helpful. stated X shoulder injury had been approved and would like to have that addressed surgically once recovered from X knee. Apparently, what was bothering X the most after X knee responded to X. stated Dr. X performed surgery on the ankle on X and was given crutches afterwards, but they aggravated X left shoulder. At the time continued to have some discomfort going up and down X left lower leg. stated this had been present since X accident. stated Dr. X had X in X. felt X left knee was much better following X. would like to have X shoulder addressed at the time. The request for X was denied by Dr. X who felt the injury seen in the shoulder was chronic. also questioned the lack of recent non operative treatment, recent MRI and recent shoulder delamination details. X stated a couple of days prior to X, twisted X left ankle in the closet and fell onto the left knee causing pain in X left hip and lower back. had a couple X left so took those with benefit and would like some more. stated X had been started for X ankle. When was subsequently seen, stated X had finished. X left knee continued to bother X. believed that was related to getting an X at the time of X ankle surgery in the medial left thigh for postoperative analgesia. felt X knee therapy was cut short because of X ankle intervention. believed it was helping X and would like to have some more. had another MRI of X left knee, so a request was made for that which was denied in X. The left knee examination was fairly benign. was ambulating with a cane due to X left hip discomfort. X-rays of the knee dated X showed X. There was less significant joint space loss in the

compartments and small bilateral osteophytes. Left knee overall did not appear to be much changed compared to x-rays taken in X. "I X" grade for the right knee was X and left knee was X, both due to X. had a pre-existing degenerative change in the left knee as x-rays taken in X showed X. MRI of the left knee post injury revealed X. X was recommended.

Treatment to date included X.

Per a Peer Review Report dated X by X, DO, the request for X was not medically necessary. Rationale: "Based on the documentation provided and per the guidelines, they requested X. The left knee is not recommended at this time. Though the claimant has a history of continued pain, secondary to the injury, there was lack of documentation of medical necessity. The claimant had significant improvement, stated from the most recent visit. There's no indication as to the need for an X. Therefore, the request for X is not medically necessary."

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Per ODG, "Recommended as an option: may be a first-line or second-line option." In this case, the claimant is status post X on X. fell on X and has left knee pain. However, there is no documentation of significant deficits of the left knee on exam. This request is not certified."

Per a Peer Review Report dated X by X, MD the request for X of

was denied. Rationale: "ODG by MCG Last review/update date: X, X: X. No specific findings. X-rays of the knee showed X. The medical necessity is not established based on a benign exam of the knee. Therefore, the requested appeal for an X is upheld."

The requested X is not medically necessary. Based on the medical documentation, there are insufficient examination findings to warrant the requested X. No new information has been 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 medical documentation, there are insufficient examination findings to warrant the requested X. No new information has been 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:**

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- TMF SCREENING CRITERIA MANUAL
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
- MILLIMAN CARE GUIDELINES
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- INTERQUAL CRITERIA
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE