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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 when X slipped and twisted the right knee. The diagnosis was tear of medial meniscus of knee and sprain of right knee.

On X, X was seen as a Workers' Compensation new patient by X, MD for right knee pain. X reported a pain score of X and described the pain as agonizing and pinching. Aggravating factors included activity, bending, exercise and prolonged standing. Decreasing factors included rest, sitting, ice, and lying down. The pain timing was intermittent, progressed during the day, affected sleep, and had no particular pattern. X restrictions involved dressing, transferring in and out of car / bed / toilet. Examination revealed a X. There was a X. There was tenderness to palpation along the X. There was X. Cruciate and collateral ligaments were X. Active range of motion measured X degrees flexion. Distal pulses were X. X was X to light touch, and X was X. MRI of the right knee was reviewed and revealed an X. An approximately X was noted in the X. The assessment was X of right knee. Recommendation was made for right knee X. A prescription dated X, by Dr. X was documented for X.

An MRI of the right knee dated X, demonstrated X.

Treatment to date included medications X.

Per a utilization review adverse determination letter dated X, the request for X; and X was denied by X, MD, as not medically necessary or appropriate. Rationale: "The ODG supports X. As X is non-certified. In this case, there is no support for X. As such, the request for X is not medically necessary. X. The ODG recommends X when there is a diagnosis of knee arthritis that is limited to a single knee compartment confirmed with imaging, the ligaments are intact, there is full thickness cartilage loss or osteonecrosis, preoperative range of motion is preserved, and there is no active inflammatory arthritis. The ODG recommends loose body removal when there is a loose body on imaging, failure of nonoperative treatment, and persistent disabling symptoms. The ODG recommends a X as an option for more complex surgical procedures. The provided documentation indicates the worker has persistent right knee pain despite treatment that has included X. The physical examination showed, X. X with associated X. In this case, the provider recommended X. As such, the request for X is not medically necessary."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "Appeal for X. Per Official Disability Guidelines, the medication is recommended for post-operative pain. As X is not

medically necessary, there is no support for X. As such, the request for X is not medically necessary. Appeal for X. Per Official Disability Guidelines, X. X. Per previous review X dated X, a request for X was non-certified because the MRI report indicated there X. In this case, the claimant was seen for right knee pain. The documentation does not show details

of conservative therapy attempted and failed. The request is also not consistent with treatment guidelines and diagnostic studies. As such, the request for Appeal for X is not medically necessary.”

Based on the submitted documentation, the requested X are not medically necessary. The submitted records do not demonstrate that the patient has attempted an appropriate course of conservative treatment. In addition, the MRI report does not describe the presence of a X. Therefore, X is not supported. No new information has been provided which would overturn the previous denials. X are 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 documentation, the requested X and its associated request are not medically necessary. The submitted records do not demonstrate that the patient has attempted an appropriate course of conservative treatment. In addition, the MRI report does not describe the presence of a X. Therefore, X are 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