

Independent Resolutions Inc.
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

Independent Resolutions Inc.
Notice of Independent Review Decision

Case Number: X

Date of Notice: X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X stated X. X was placing a X. Pain gradually developed in X medial knee over the next few days. The diagnosis was other tear of medial meniscus, current injury, right knee (X); other internal derangements of right knee (X), and pain in right knee (X).

On X, X, MD evaluated X for a follow-up of right knee pain. X was X status post injury. X stated X would like to discuss scheduling X. X had constant pain on the medial aspect, had progressively worsened. X was not taking medication for pain. X had no prior injuries or surgeries. A few instances of instability, specifically with stairs were noted. X had started X which was not helpful. X had used X to treat the condition. Right knee examination revealed X.

Treatment to date included X.

Per a peer review and utilization review adverse determination letter dated X by X, MD, the request for X was denied. Also, X were also denied. Rationale for X: "Per Official Disability Guidelines Knee and Leg (Updated X), Diagnostic Knee Arthroscopy. "Conditionally Recommended. Recommended as an option; may be a first-line or second-line option. ODG X. Worsening knee symptoms despite treatment with X. Imaging performed and ALL of the following are present: X." In this case, the claimant had complaints of right knee pain. The claimant reported of constant pain. The examination showed X. There was X McMurray's test. There was limited X. However, there is no documentation of an MRI indicating a X. As the X is not supported, a X are also not supported. Furthermore, there is no

Independent Resolutions Inc.
Notice of Independent Review Decision

Case Number: X

Date of Notice: X

documentation that the claimant had X. Therefore, this request is not medically necessary and is not certified.” Rationale for X: “In this case, the requested X was not performed. Therefore, this request is not medically necessary and is not certified.”

Per a peer review and reconsideration / utilization review adverse determination letter dated X by X, MD, the request for X were also denied. Rationale for X: “ODG by MCG Last review/update date: X "Recommended as an option; may be a first-line or second-line option. ODG by MCG Last review/update date: X "Recommended as an option; may be a first-line or second-line option. The requested X is not medically necessary. There is no documentation provided to demonstrate that the patient has attempted and failed appropriate conservative measures. Thus, the guidelines have not been met. As the X is not medically necessary, the ancillary requests are not indicated. Therefore, the appeal request for X is upheld and is non-certified.” Rationale for X: “The X request is not recommended. Thus, the associated requests are not necessary. Therefore, the appeal request for X is upheld and is non-certified.” Rationale for X: “The requested X is not medically necessary. There is no documentation provided to demonstrate that the patient has attempted and failed appropriate conservative measures. Thus, the guidelines have not been met. As the X request is not medically necessary, the ancillary requests are not indicated. Therefore, the appeal request for X is upheld and non-certified.”

The records provided for review did not include a formal MRI report for the right knee to support the X request that includes X. Therefore, the X request is not supported as medically necessary. As the X request is not indicated, there would be no requirement for a X. Therefore, the previous denials are upheld. 1. 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:

The records provided for review did not include a formal MRI report for the right

Independent Resolutions Inc.
Notice of Independent Review Decision

Case Number: X

Date of Notice: X

knee to support the X request that includes X. Therefore, the X request is not supported as medically necessary. As the X request is not indicated, there would be no requirement for a X. Therefore, the previous denials are upheld. 1. X are not medically necessary and non-certified

Upheld

Independent Resolutions Inc.
Notice of Independent Review Decision

Case Number: X

Date of Notice: X

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