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IRO Certificate #X

Notice of Independent Review Decision

DATE OF REVIEW: X

IRO CASE NO. 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:

Upheld	(Agree) <input checked="" type="checkbox"/>
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

Request for X has been denied as medically unnecessary.

Adverse Determination Letter, X, LVN, Utilization Management Review, X, as not medically necessary.

Peer Review by X, MD, X, as not medically indicated, based on X review of the medical records. X felt the ODG criteria were not met and, therefore, the request for the procedure was non-certified.

Appeal Reconsideration Letter, X, X, LVN, Utilization Management Review, also was non-certified.

Peer Review by X, MD, X, for the same procedure was again non-certified stating X reason for non-certification was the MRI report does not detail a X.

Progress note generated by X, PA-C, on X, detailing patient's presenting X. An examination of the right knee showed X. Plan was to start X.

PATIENT CLINICAL HISTORY SUMMARY (continuation)

No medications were prescribed. X was returned to work without restriction.

Second note by X, dated X, follow up for right knee injury. X presented with complaints of pain and swelling and unable to put weight on knee or bend the knee. Exam shows X.

Assessment was right knee contusion and right knee strain, avascular necrosis of right femur. Patient was referred to orthopedic surgeon. No medications were prescribed. X was allowed to return to work with out restrictions.

Office note generated by X, MD, orthopedic surgeon, dated X. Patient presents for further evaluation and treatment of right knee pain after on-the-job injury. X reports pain and popping and catching and stiffness of the right knee. Physical examination showed X.

X-rays of the right knee were taken X showing X. Equivocal OCD (Osteochondritis Dissecans) lesion proximal patella seen on the lateral view. Also noted are lab studies, chest x-ray, and review of the MRI results. Dr. X assessment was the patient had sustained injury to right knee with internal derangement of right knee involving posterior horn of lateral meniscus, avascular necrosis of lateral condyle of right femur, acute medial meniscus tear. X recommended patient undergo X.

Per X note by X, PA-C, patient presented with follow up for right knee injury, Reports that X was not approved and that X currently is not working due to X light duty and that X knee is in constant pain and has bruising and swelling and has stiffness in the knee.

Examination at that time showed X. Assessment was knee strain, contusion, and avascular necrosis of the right femur. Patient was prescribed X. X was allowed to return to work with restrictions.

MRI w/o contrast performed on X. Assessment was X. Also noted X. I did not see any mention of collapse of the articular surface.

Also reviewed x-ray of the right knee, X views, performed X, showing X.

Summary: X sustained right knee injury work related. Treated with X. MRI report indicated X.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION

Opinion: I agree with the benefit company's decision to deny the requested service.

Rationale:

I do not feel there is radiographic evidence supporting the diagnosis of unstable meniscus tear. There is also X. I also feel the patient has not had X.

The requested service, X, is not medically justifiable/necessary at this time.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE & EXPERTISE IN ACCORDANCE WITH
ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE DESCRIPTION)