

**US Decisions Inc.**  
**An Independent Review Organization**  
**3616 Far West Blvd Ste 117-501 US**  
**Austin, TX 78731**  
**Phone: (512) 782-4560**  
**Fax: (512) 870-8452**  
**Email: [@us-decisions.com](mailto:@us-decisions.com)**

***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)

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:** • Notice of Adverse Determination – X

**PATIENT CLINICAL HISTORY [SUMMARY]:** X who was injured on X. The diagnosis was complex tear of medial meniscus of right knee. There are no office visits available for review. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “ODG notes that X. MRI findings are X. ODG notes that X. In this case, records do X. There is no documentation of X. There is X. Therefore, this request is not medically necessary. “Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “ODG notes that X. There should have been X. ODG notes that X. In this case, the claimant presents with right knee complaints after a reported X. Upon discussion, Dr. X reviewed the chart while the case was discussed. The documentation does X. There is no evidence of X. Furthermore, there are no specific objective findings consistent with X. There is no evidence of X. Given exam findings are not consistent with MRI findings, this request is not medically necessary. “No medical records have been provided for the independent review. Therefore, 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:**

No medical records have been provided for the independent review. Therefore, 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:**

- 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)**