

IRO Certificate No: X

Notice of Workers' Compensation Independent Review Decision

X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a X who was working as an X on date of injury X who was X. On X presented as an ambulatory walk-in patient at X. Examination showed no visible ecchymosis and tenderness at the left hip and knee and lumbar stiffness. Body mass index (BMI) was recorded as 45. Radiographs of the left hip and knee were negative for abnormality. Contusion of the left hip and knee was diagnosed and nonsteroidal anti-inflammatory medication was prescribed. The patient remained off work and was referred to X, DO/X, PA for office visits for continued left knee pain and swelling and left hip and lumbar spine tenderness. This led to magnetic resonance imaging (MRI) of the left knee X which showed a meniscal tear. Primary care was changed to X. Orthopaedic surgical consultation was obtained regarding left knee pain at X with X, MD in X on X with physical therapy being recommended. MRI scan of the left hip on X showed mild degenerative changes. MRI of the lumbar spine done X showed mild degenerative changes. Consultation was obtained with X

, MD on X; left hip examination was negative for tenderness, internal rotation of X degrees, external rotation of X degrees, no pain with rotation, no impingement, positive FABER test. Left hip x-rays showed good joint space and no fracture. Lumbar spine x-rays showing lumbar scoliosis with osteophytes. No surgical indication was found at the left hip or lumbar spine. On X Dr. X performed X; chondromalacia degenerative changes were visualized at the patellofemoral joint, femur, and tibia at arthroscopy. Following the knee arthroscopy the patient complained of lumbar spine and left hip pain interfering with progress in physical therapy. On X at the left knee post op appointment for X, X performed X. X for the left knee was continued for several weeks. On X, X performed a X was not successful. X was performed X at X by X, M.D. X take one every 8 hours as needed for pain was filled on X and X, take on twice a day was filled on X. Follow-up appointment on X at X with X, APRN documented the X helped for only 3-4 days. Lumbar spine examination showed X. Left hip examination showed X. Results from X MRI scans of lumbar spine, left hip and pelvis showing mild degenerative changes on all scans were reviewed. Impression was status post left knee arthroscopy partial meniscectomy with chondromalacia identified, lumbar strain, myofascial pain, sacroiliac dysfunction, left leg radicular symptoms, left hip contusion. Request was placed for X.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND

CONCLUSIONS USED TO SUPPORT THE DECISION: X is not medically necessary as the diagnosis of symptomatic osteoarthritis has not been made based upon physical examination, plain x-ray and MRI findings. If symptomatic osteoarthritis were to be diagnosed, X clinical practice guidelines recommend X.

X is not medically necessary as clinical practice guidelines do not recommend such X.

SOURCE OF REVIEW CRITERIA:

- ACOEM – American College of Occupational & Environmental Medicine UM Knowledgebase
- 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

- ODG- Official Disability Guidelines & Treatment 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)

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

ATTESTATIONS:

- X

Attestations:X
A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN
OR HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:X