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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 Overtuned (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: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X is a X who was injured at work on X while working at a X. X sustained a fall, twisting X knee and felt a popping sensation and knee pain. The diagnosis was left knee medial meniscus tear. On X, X, PA / X, MD saw X for initial evaluation of X left knee. X reported X sustained a fall at work on X, twisting X knee and felt a popping sensation followed by medial-sided knee pain that had persisted since the incident. X had a history of X. X had attempted a course of X. Left knee examination noted X. Gait was antalgic. Per the note, left knee MRI dated X was reviewed and revealed X. The assessment was left knee medial meniscus tear. It was noted that X had evidence of X on MRI. X had X. It was recommended X undergo a X. It was recommended X continue with X current work restrictions and be seen back for preoperative evaluation prior to X surgery. Per the visit note dated X by X, PA / Dr. X, left knee MRI dated X was reviewed and revealed X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “ODG states that X. The records do not support that this claimant has been X. This claimant has not X. There is also no evidence

that this claimant's clinical or functional status is X. Considering that the claimant does not meet the guideline criteria for X, 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, as not medically necessary or appropriate. Rationale: "ODG states that X. In this case, the claimant is about X months from the reported date of injury of X. The records do not show documentation of X, as required by the guidelines. There are also no records indicating that the claimant has attempted X. There is no evidence of worsening symptoms despite conservative measures. Additionally, there is no evidence of mechanical symptoms of knee locking blocking or catching that would support performing the X in the acute setting. Considering that the claimant does not meet the guideline criteria for X, the request for X is not medically necessary." Thoroughly reviewed the documents submitted and agree the request does not meet ODG guidelines. Also there is no evidence of attempted X. Therefore the requested 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:

Thoroughly reviewed the documents submitted and agree the request does not meet ODG guidelines. Also there is no evidence of attempted X. Therefore the requested 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)**