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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 who was injured on X. X sustained a left knee injury during a X. The assessment included X. X was seen by X, FNPC on X for a follow-up. X was X. X stated that X range of motion and strength were improving with X. X stated that X was really helped more than anything. X reported mostly, weakness and stiffness were still present, although improving. On examination of the left knee, a X was noted. There was a X. A X was noted. Range of motion was limited by mild pain. Range of motion was from X degrees. It was painful with flexion and extension. X was noted over the X. X was decreased in all muscle groups. It was X with the quadriceps and hamstrings. The degree of weakness was X. Treatment plan was to continue X. X attended a X session by X, DPT on X for left knee pain. X stated that X had not returned back to work, but noted some pain with prolonged standing, walking, and with steps at work. The pain was rated at X, X at worst. X had completed X. On examination of the left knee, range of motion showed X degrees of flexion and X degrees of extension. Strength was +X with flexion, extension, and hip abduction. The assessment included pain in left knee. X was making steady progress at the time, but continued to demonstrate deficits in full knee extension that limited X ambulation and resulted in an abnormal gait. X continued to demonstrate improvement in X, but remained limited. Plan of care was continued. An MRI of the left knee dated X showed a X. X was intact. X was noted. There was X. Treatment to date included X on X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “Per Official Disability Guidelines (ODG), X: Medical treatment: X” are recommended. In this case, the claimant is noted to have been treated with X, having completed X. However, in the documentation provided, a recent orthopedic progress note was not provided for review. Additionally, there is no evidence provided for review that would indicate the claimant cannot address any X. X are excessive in nature and exceed guidelines criteria. Therefore, medical has not been established. “Per a reconsideration review adverse determination letter dated X, the prior denial was upheld by X, MD. Rationale: “The request for X exceeds guideline recommendations. There are no recent office visit notes detailing the medical necessity for X and why a medical

exception should be made, overriding medical treatment guidelines. Therefore, the requested X, is denied. The requested X for the left knee is not medically necessary. The records reflect that the claimant has X. The guidelines only recommend X. The claimant has already exceeded the recommended guidelines. In addition, the claimant should be well versed in a X. The medical records and associated examination findings do not demonstrate extenuating circumstances which would supersede the recommended guidelines. No new information has been provided which would overturn the previous denials. X as requested by X, M.D. with 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:**

The requested X is not medically necessary. The records reflect that the claimant has X. The guidelines only recommend X. The claimant has already exceeded the recommended guidelines. In addition, the claimant should be X. The medical records and associated examination findings do not demonstrate extenuating circumstances which would supersede the recommended guidelines. No new information has been provided which would overturn the previous denials. X as requested by X, M.D. with 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)**