

IRO Certificate No: X

Notice of Workers' Compensation Independent Review Decision

Date of Notice: X

Date of Amendment: X

TX IRO Case #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]: This case involves currently a X (DOB: X) who sustained a work-related injury on X. X diagnosis is unilateral primary osteoarthritis of the left knee (X). The request is for a X.

X, Adverse Determination Letter, X, X, X, Clinical Summary, the claimant was evaluated for X. X is X. The plan was for a X. On recent examinations, there was X. There is a history of X. X comorbidities consist of X. The X was requested. According to ODG by MCG, X, X Treatment type: CR Recommended as an option; may be a first-line or second-line option. ODG Criteria Repeat evaluation of specific area or structure with same X: Clinical need for X, as indicated by 1 or more of the following: X. The request for the X is not considered medically necessary as there is no rational listed in the

documentation provided for the requested X. A X was completed X. Therefore, the request is non-certified.

X, Physician Advisor Determination, X, MD, (X), the claimant was evaluated for X. X is status post X. X continues to experience pain and popping in the left knee affecting X daily living. Examination revealed X. X-rays done showed X. A plan for a X. During the peer-to-peer, X, PA noted the request for an X is for the X. This is due to the X.

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

The request for a X is not medically necessary as it is not supported by ODG, as it is not recommended for a suspected diagnosis of X. Therefore, the patient does not meet the ODG guidelines.

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)

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