Clear Resolutions Inc.

An Independent Review Organization
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11/19/18

Description of the service or services in dispute:
XX

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified Orthopedic Surgeon

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

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

Patient Clinical History (Summary)
XXXX. XXXX was diagnosed with XX XX (XX). The pain was rated at XX/10.

XXXX was evaluated by XXXX for the complaints of XX XX pain, XX / XXXX. Examination of the XX XX showed XX to XX in the XX and XX joint line, XX/5 muscle strength in flexion and extension, positive XX and lateral XX test, XX XX test, XX XX XX test, and XX XX XX sign.

An XX of the XX XX dated XXXX showed moderate XX of the XX XX XX ligament near the XX attachment; XX XX throughout the XX XX XX body and XX horn with complex XX XX of the XX horn near the XX; XX XX throughout the XX XX.

The treatment to date consisted of medications (XXXX), XX therapy, XX XX XX on XXXX, XX and XX under anesthesia (XX) on XXXX, XX XX to below XX XX XX bypass and XX and ligation of native XX XX to prevent extension of XX on XXXX.

The previous XX XX of XX and XX under anesthesia on XXXX found that the XX was slightly XX, but intact and the XX was noted to be XX. The provider indicated that XX maneuver was performed under anesthesia which demonstrated a good XX. No XX XX or XX XX XX was noted. XX of the small XX tear of the XX root XX meniscus was performed. Minimal XX was noted XX compartment. No XX findings were noted XX compartment. An examination of the XX XX was not noted.

Per an initial adverse determination letter and a peer review summary dated XXXX, the request was noncertified. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The specific subjective and objective clinical findings were insufficient to fully necessitate the procedures. There was no documentation that the patient had a failure of previous XX or other XX repair procedure as well as a XX support an XX procedure. In addition, the XX of the XX XX with and without contrast dated XXXX documented XX XX throughout the XX XX XX body and XX horn with complex XX XX of the XX XX near the XX. There was also no documented XX or XX way, significant XX at the time of injury, or description of injury indicates XX as well as a positive XX sign, positive pivot shift, or XX to fully necessitate an XX reconstruction. Adequate compliance, objective response, exhaustion, and failure from indicated conservative treatments prior to the consideration of surgery could not be validated in the limited records. Moreover, the guidelines indicated that XX repair is under study and no randomized or quasi-randomized controlled studies were identified. Clarification is needed regarding the request and how it might affect the patient's clinical outcomes. Clear exceptional factors could not be identified."

A letter of medical necessity was documented by XXXX had rupture of XX of XX XX, XX of XX XX of XX XX, and tear of XX of XX XX. XXXX had undergone XX therapy exercises XX times a week, but did not respond to the prior therapies. XXXX had undergone XX of XX and XX on XXXX. XXXX continued to experience pain, XX. The pain level increased with activity. XXXX was doing XX therapy XX times a week and XX exercises as well. On follow-up visit with XXXX, XXXX continued to complain of XX XX XX and XX / XX since the accident at XX in XXXX.

Per a reconsideration review adverse determination letter dated XXXX and a review summary dated XXXX, the request was noncertified. Rationale: "XX

Per an appeal letter dated XXXX on behalf of XXXX, the request had been denied as the injury was not work related. XXXX had XX XX XX at XXXX hospital and from there went to XXXX for a follow-up of XX XX. XXXX consulted XXXX, and through an XX with contrast, XX in the XX that had occurred due to a XX hitting the XX area XXXX.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

Based on the documentation available, I would recommend upholding the prior denial.

The ODG supports the utilization of operative intervention is an option for management of injuries of the XX including XX, isolated XX injuries, and XX tearing. The documentation available indicates that the injured worker sustained a XX with XX of XX artery requiring prior XX surgery. A diagnostic XX with XX under anesthesia and XX was performed in XXXX and demonstrated an XX and functioning XX on the exam under anesthesia. The subsequent notes from the provider indicating XX of the XX during the office visit represent inconsistency with the prior exam performed under anesthesia. Additionally, no significant XX XX pathology was noted at the time of the diagnostic XX intervention in XXXX. While XX therapy was implemented, the progression to surgical intervention would not be supported given the contradictory objective exam findings and when noting the extensive surgical intervention which

has been proposed as well as the understudy recommendation the ODG regarding PCL reconstruction, the proposed operative intervention would be considered not medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

☐ ACOEM-America College of Occupational and Environmental Medicine

☐ AHRQ-Agency for Healthcare Research and Quality Guidelines

☐ DWC-Division of Workers Compensation Policies and 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 and Treatment Guidelines

☐ Pressley Reed, the Medical Disability Advisor

☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters

☐ Texas TACADA Guidelines

☐ TMF Screening Criteria Manual

☑ Peer Reviewed Nationally Accepted Medical Literature (Provide a description)

Evidence-Based ACL Reconstruction.
Rodriguez-Merchan EC1.

Clin Sports Med. 2018 Apr;37(2):307-330. doi: 10.1016/j.csm.2017.12.008.
Knee Cartilage Repair and Restoration: Common Problems and Solutions.
Welton KL1, Logterman S2, Bartley JH1, Vidal AF3, McCarty EC1.

☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

Appeal Information

You have the XX to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.