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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

XX Request for review by an Independent Review Organization

XX Letter of denial

XX Request for preauthorization

XX Case request order

XX Progress notes by. XXXX, MD

XX Progress note by XXXXXX. XXXX, PA

XX Progress note by XXXX XXXX, MD

XX Progress note by XXXX XX. XXXX

XX Progress note by XXXX XX. XXXX. MD

XX Physical therapy notes

XX Progress note by XXXX XX. XXXX, MD

XX Progress note XXXX XX.XX, MD

XX Op notes by XXXX XX. XXXX, MD

XX Progress note XX, MD

XX X-ray XXXX 4 Views XXXX

XX MRI XXXX XXXX without contrast

XX Ultrasound XX XXXX venous

XX X-ray XXXX 4 views XXXX

XX X-ray XXXX 4 views XXXX

XX X-ray XXXX 4 views XXXX

XX X-ray XXXX 4 views XXXX

XX MRI XXXX XXXX without contrast

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XX-year-old XXXX XX who sustained work related injury on XXXX as a result of a XXXX to XXXX XXXX XXXX. XXXX underwent XXXX XXXX medial XX ligament reconstruction, XX, patellar and XX on XX. XXXX continued to have pain and functional deficits following surgery. XXXX underwent extensive physical therapy postoperatively. Treatments included XX, XX, XX, XX, modified duty, XX exercise program, work restrictions, and XX XX program. XXXX underwent repeat MRI of XXXX XXXX on XX which revealed XXXX medial XX reconstruction with XX, XX, suspected progressive complex tear anterior XX and similar appearance of the medial XX, interval XX with artifact, chronic sequelae of XX, and mild XXXX XX with interval XX. XXXX saw Dr. XXXX on XX at which point XXXX pain and functional deficits continued. Physical exam was consistent with 5-10 degrees of flexion contracture, full flexion, tender over XX, pain with valgus and extension, positive XX, and 1 XX displacement. XXXX was recommended for XX medial and lateral with XX. This case underwent 2 previous adverse determinations on XX by Dr. XXXX due to inability to discuss case with provider and on XX by Dr. XX due to lack of MRI evidence.

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

Based on the review of records submitted, the request for XXXX XXXX arthroscopic medial and XX is supported by ODG based on updated MRI and correlating physical exam findings. This claimant has failed an extensive trial of non-operative modalities following surgery on XX. XXXX has MRI findings consistent with XX, and XXXX physical exam findings are consistent with medial and XX line pain and positive XX test. XX pathology is common especially following an extensive surgical procedure such as distal XX and XX ligament reconstruction. In regards to the request for XX for the XXXX XXXX, the claimant does not meet all the ODG criteria for XX. The MRI submitted for review showed no evidence of large unstable XX defect. Therefore, the medical necessity for XX for the XXXX XXXX is not supported by ODG.

In summary, based on the ODG, the request for coverage of XX for the XXXX XXXX is medically necessary and appropriate. However, the request for XX of XX for the XXXX XXXX is not medically necessary and appropriate. Thus, the request is partially overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

XXXX and XX (updated 4/25/2019)

ODG Indications for Surgery™ -- XX:

XX

ODG Indications for Surgery™ -- XX or XX repair:

XX