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***Notice of Independent Review Decision***

***Amendment X***

**IRO REVIEWER REPORT**

**Date:X**; Amendment 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 Overturned Agree in part/Disagree in part

☐ Upheld Agree

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

• X

**PATIENT CLINICAL HISTORY [SUMMARY]:**

**X** who was injured on X. X reported a X. The diagnosis was status post bilateral quadriceps tendon rupture and repair in bilateral knees. On X, X was evaluated by X, PT for physical therapy evaluation visit. The medical diagnosis was status post bilateral quadriceps tendon rupture and repair in bilateral knees. The PT diagnosis was decreased X. X was hospitalized in X from X due to X. X was also X. X had a quadriceps tendon rupture and repair bilateral knees on X on the right side and X on the left. X reported having a history of X. Prior to surgery, X was X. The goal was to return to prior level of function (PLOF). It was noted that X was confined to home as X was status post bilateral quadriceps tendon rupture and repair in both knees. Leaving home required a considerable and taxing effort for X and X was unable to leave home. X needed the assistance of another person to leave the home. X lived with X and around the clock assistance was provided for activities of daily living, meals, and transportation. X lived in a single-story home and 1 little step up entry and 1 dog. No safety hazards were identified. On examination, blood pressure was 149/90 mmHg. The X. The endurance revealed impairment, and was limited to short household distances. X had bilateral knee pain with touch, movement and relieved by rest, rated as X, interfering with mobility and ambulation. The muscle strength of bilateral hip joints was X, and bilateral ankle strength was X. The bilateral knees were not tested due to X having knee lock at 0 degree. X was using assistive device. X did sponge baths. X was weightbearing as tolerated. X used a knee brace lock. It was noted that X was status post bilateral quadriceps tendon rupture and repair in bilateral knees. X was hospitalized and underwent X hours of physical therapy in X. Prior to X, X presented to X. X demonstrated X. X had X-hour assistance and supervision available to decrease the risk. X would benefit from X. Treatment to date included X. Per a utilization review and peer review report dated X by X, DO, the request for X was denied as not medically necessary. Rationale: “According to the guidelines, X. There was no documentation that the claimant required X. There was also no documentation

detailing what specific functional goals are to be achieved that could not be met by X. Therefore, the request for X is not medically necessary." The request for X was denied as not medically necessary. Rationale: "According to the guidelines, X. There was also no documentation detailing what specific functional goals are to be achieved that could not be met by X. Therefore, the request for X is not medically necessary." The request for X was denied as not medically necessary. Rationale: "According to the guidelines, X. There was also no documentation detailing what specific functional goals are to be achieved that could not be met by X. Therefore, the request for X is not medically necessary." On X, Dr. X wrote an appeal letter for authorization denial for X. X wrote that the reason stated in the denial letter dated X "does not meet established standards of medical necessity." Authorization was approved for X, and per doctor's orders and Dr. X evaluation, X to be medically necessary, as prescribed. Due to X right quadriceps tendon repair on X and left quadriceps repair on X, X will need work on X; therefore, it was imperative X be provided with the required and needed X. Per a reconsideration review adverse determination letter and a peer review report dated X by X, MD, the appeal request for X was denied. Rationale: "The request for the Appeal / X is not medically necessary. In this case, the criteria by the guidelines have not been satisfied. There have not been reported any major surgical interventions nor do the physical/clinical findings indicate the medical necessity for the requested services, it is unclear why the claimant is being recommended to get X. Therefore, the request for the Appeal / X is not medically necessary." The appeal request for X was also denied. Rationale: "The request for the Appeal / X is not medically necessary. In this case, the criteria by the guidelines have not been satisfied. There have not been reported any major surgical interventions nor do the physical/clinical findings indicate the medical necessity for the requested services. It is unclear why the claimant is being recommended to get X. Therefore, the request for the Appeal X is not medically necessary." Thoroughly reviewed provided records including peer reviews. Patient meets criteria for X as established by the cited ODG criteria from peer reviews. Patient had a period of hospitalization after surgical intervention. Patient with great difficulty in leaving the home. All of the necessary information is in documentation. X request is warranted.X;X; and X is medically necessary and certified

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS,**

**FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

Thoroughly reviewed provided records including peer reviews.Patient meets criteria for X as established by the cited ODG criteria from peer reviews. Patient had a period of hospitalization after surgical intervention. Patient with great difficulty in leaving the home. All of the necessary information is in documentation. X request is warranted. X is medically necessary and certified Overturned

**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

☐ 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

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TMF SCREENING CRITERIA MANUAL