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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 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 was X. The diagnosis was status post anterior cruciate ligament (ACL) reconstruction on the let with Achilles allograft and rupture of anterior cruciate ligament of left knee.

On X, X, MD evaluated X for left knee complaints. X had a history of X. X noted instability upon ambulation. On examination of left knee, there was trace effusion. X had well healed X. Lachman's test X. Range of motion was full in X. Straight leg raise was X. The MRI of the left knee was reviewed. Based on the history and physical examination, it appeared that X previous X. Dr. X recommended proceeding with revision procedure. X would be scheduled for X.

An MRI of left knee dated X revealed X. There was early X. Posterior X was diminutive in size possibly due to remote injury or prior partial intervention. No discrete tear was seen.

Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: "Per Official Disability Guidelines (ODG), "X." In this case, the claimant has noted X. Physical exam of the left knee revealed X. MRI of the left knee dated X and signed by X MD revealed X. The claimant has continued complaints and objective findings, with MRI confirmation of X. However, there was no evidence of the X. There was no evidence of X. Therefore, medical necessity has not been established."

Per a reconsideration / utilization review adverse determination letter dated X, by X, MD, the request for X was denied. Rationale: "ODG by MCG Last review/update date: X, "X for Knee and Leg Conditions Treatment type: Diagnostic Testing, Surgery Conditionally Recommended-CR Recommended as indicated below only for symptomatic post-traumatic knee injuries, without presence of any detectable degenerative knee disease, following a prescribed period of conservative care." "The patient was diagnosed with a sprain of the anterior cruciate ligament of the left knee. The requested surgery procedure is not medically necessary. The submitted medical records do not indicate that the patient has X. As such, the guidelines have not been met." Per the addendum, "A. peer review with the treating provider, Dr. X did occur. The treating provider indicated that the patient

has not had a X. Thus, the guidelines have not been met for the requested procedure. No new information was provided that would warrant the requested procedure. Therefore, the requested X, is denied."

The claimant presents with an unstable left knee on the X evaluation. Review of the X left knee MRI clearly shows a X. With this type of pathology, revision reconstruction is clearly indicated. There is no role for non-operative measures for this type of pathology. Therefore, it is this reviewer's opinion that medical necessity is established and the previous denials are overturned. X as requested by X, M.D. with X is medically necessary and certified.

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

The claimant presents with an unstable left knee on the X evaluation. Review of the X left knee MRI clearly shows a X. With this type of pathology, revision reconstruction is clearly indicated. There is no role for non-operative measures for this type of pathology. Therefore, it is this reviewer's opinion that medical necessity is established and the previous denials are overturned. X as requested by X, M.D. with 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:

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

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

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE