

CPC Solutions

An Independent Review Organization

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Notice of Independent Review Decision

Case Number: X

Date of Notice: X

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

X

Description of the service or services in dispute:

X.

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)

Information Provided to the IRO for Review:

X

Patient Clinical History (Summary)

The patient is a X whose date of injury is X. X was X. X foot did not move as X twisted to the right and X had a pop in the knee and swelling. MRI right knee dated X shows X. The distal aspect of the X. Office visit note dated X indicates that the patient complained of right knee pain. The physical examination revealed X. The range of motion (ROM) was X degrees. The claimant wears braces. X BMI is 36. Previous treatment includes X. The request was for X. The claimant was instructed to return for a follow-up visit in X weeks. Work status was not stated. Diagnosis: chondromalacia, sprain of MCL of knee, tendinitis of right quadriceps tendon.

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

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The request for X is not recommended as medically necessary and the previous denials are upheld. The initial request was non-certified noting that, “X diagnoses include knee chondromalacia and tendonitis. ODG does not support X. As such, the medical necessity of this request has not been established. Therefore, the request for X is not medically necessary.” The denial was upheld on appeal noting that, “The guidelines do not recommend this treatment for the knee. As such, the requested treatment exceeds the guideline recommendations. There is no extenuating circumstances documented to support the overturning of the previous denial. Therefore, the request for X is upheld and non-certified.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no serial treatment records provided. Current evidence-based guidelines note that X is not generally recommended as evidence shows inconclusive benefit, lack of benefit, or potential harm. X is specifically not recommended for knee pain or injury. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

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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 um knowledgebase
- 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
- Internal 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
- TMF Screening Criteria Manual

- Peer Reviewed Nationally Accepted Medical **Literature** (Provide a description)

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