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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 Overtuned (Agree in part/Disagree in part)

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- X

PATIENT CLINICAL HISTORY [SUMMARY]:

X who was injured on X. X was X. The diagnosis was rupture of anterior cruciate ligament of left knee, subsequent encounter, and pain in left knee.

X was evaluated by X, MD on X for follow-up of sprain of anterior cruciate ligament of left knee joint. X presented with left knee pain in the setting of ACL tear. X had been undergoing X. X recently had another instability event resulting in a X. X presented that day for repeat examination and surgical scheduling. examination of the right knee revealed X. Range of motion was tolerated from X. There was X. X was X. There was pain but X. The assessment was rupture of anterior cruciate ligament of left knee, subsequent encounter, and pain in left knee. Dr. X noted that MRI of the left knee showed X. Given X persistent instability and inability to progress with X, Dr. X recommended proceeding with X as soon as possible. X had X at that time.

An MRI of the left knee dated X, revealed at X.

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “X" The patient has a diagnosis of an anterior cruciate ligament (ACL) rupture with magnetic resonance imaging (MRI) confirming presence of a high grade partial tear. There is functional knee instability present. Magnetic resonance imaging (MRI) does not reveal evidence of injury to the X. ODG recommends an X. There is no documentation of at least X months of nonoperative therapy given the date of injury is X. Therefore, the requested X is denied. 2. The requested X is denied. Therefore, the requested X is denied.”

Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: “The Official Disability Guideline states that X may be indicated when there is X. The Official Disability Guideline states that a X may be indicated for X required. In this case, X the patient reports left knee pain. On exam, left knee range of motion is X. X sign. X noted. Left knee X. MRI left knee

showed X. However, there is no documented evidence that the patient had at least X. There is no documentation of knee instability such as buckling and giving way in the physical examination. As such the request for X is noncertified."

Per a reconsideration review adverse determination letter dated X, the appeal request for X was denied by X, MD. Rationale: "The Official Disability Guideline states that X. The Official Disability Guideline states that a X. In this case, X the patient reports left knee pain. On exam, left knee X. X sign. X noted. Left knee X. MRI left knee showed X. However, there is no documented evidence that the patient had at least X. There is no documentation of knee instability such as buckling and giving way in the physical examination. As such the request for X is noncertified.

The requested X is not medically necessary. The records do not reflect that the patient has attempted at least X. There is no documentation that the patient has been discharged from X. No new information has been provided which would overturn the previous denials. X are not medically necessary and non-certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The requested X is not medically necessary. The records do not reflect that the patient has attempted at X. There is no documentation that the patient has been discharged from X. No new information has been provided which would overturn the previous denials. X are not medically necessary and non-certified.

Upheld

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**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **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**
- ☐ **PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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)**