

## Notice of Independent Review Decision

### Description of the services in dispute

X

### Description of the qualifications for each physician or health care provider who reviewed the decision

The professionally certified health care provider is board-certified in X

### Review outcome

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)

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

The claimant is a X diagnosed with unspecified internal derangement of the left knee, sprain of the unspecified collateral ligament of the left knee (subsequent encounter), and sprain of the anterior cruciate ligament of the left knee (subsequent encounter). This review is to determine the medical necessity of X.

The Peer Review Report by X dated X stated that the claimant had sustained an industrial injury on X. "X felt a pop in the left knee when X was using force with an X. The patient is status X. Postoperative treatment has included X. Work status is modified duty." As of the evaluation note on X, the claimant was referred for X for the left knee, to X. A peer review report from X stated that the claimant's work restrictions in place included, "...X may not lift/carry objects more than X lbs for more than X hours per day."

The Physical Therapy Daily Note by X dated X stated that, "X has reached X. Strength and stability is gradually improving as pt is now able to perform X. Lifting was also Increased by several pounds but still kept relatively

light as to avoid excess loading to the ACL. Finished w/ gentle agility-based exercises at low amplitude and speed as this is all pt can tolerate for now, but anticipate this will improve w/ time. Thus, X would benefit from X. The Physical Therapist also recommended that the claimant X.

Finally, the Denial Letter by X dated X stated that, "On behalf of the carrier /payor noted above, we decided that the services or treatments described below are not medically necessary or appropriate. This means that we do not approve of these services or treatment. This decision is the result of the appeal/reconsideration that was requested for the below treatment: X.

### **Analysis and explanation of the decision, including clinical basis, findings, and conclusions used to support the decision**

The claimant is a X diagnosed with unspecified internal derangement of the left knee, sprain of the unspecified collateral ligament of the left knee (subsequent encounter), and sprain of the anterior cruciate ligament of the left knee (subsequent encounter). This review is to determine the medical necessity of X.

The claimant is X. According to the ODG Guidelines regarding an X, it is a reasonable option to request an X at this post-operative standpoint to X. The X provides an objective point of reference to help confirm on a per patient basis whether a claimant is ready and capable of work-task specific performance. An X in this case at the X month post-operative point is, therefore, indicated and recommended.

Therefore, it is the professional opinion of this medical reviewer to overturn the denial for X due to medical necessity.

### **Description and source of the screening criteria or other clinical basis used to make the decision**

- ACOEM - American College of Occupational and Environmental Medicine Um Knowledgebase
- AHRQ - Agency for Healthcare Research and 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
- 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)

