Clear Resolutions Inc.

An Independent Review Organization
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Description of the service or services in dispute:

XX and XX days of inpatient hospital stay.

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

Board Certified Orthopedic Surgery

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

☑ Overturned (Disagree)
☐ Upheld (Agree)
☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XXXX. XXXX was diagnosed with XX primary XX of the XX XX (XX.XX). The additional diangoses were XX XX of XX XX, current injury, XX XX, initial encounter (XX.XX); unspecified XX of unspecified XX, current injury, XX XX, initial encounter (XX.XX).

XXXX for the evaluation and treatment of XX XX pain. XXXX. XXXX had undergone conservative management for XXXX injury with XXXX including XX therapy and XX injections. XXXX eventually had a XX XX XX done in XXXX. XXXX was XX months status post surgery. XXXX underwent XX therapy after the procedure. XXXX continued to have discomfort in the XX XX. This prompted XXXX to discuss right XX XX XX. XXXX used a XX to XX on the XX XX XX. On examination, XXXX had an XX XX on the XX XX XX. Examination of the XX XX revealed range of motion of XX to XX degrees and XX XX XX test. There was tenderness along the XX and XX XX lines, and XX XX of the XX. XXXX was interested in pursuing a XX XX as XXXX had failed conservative management for treatment of the XX.

X-rays of the XX XX done on XXXX demonstrated moderate-to-severe XX changes in the XX XX, XX XX XX, and XX XX. XXXX had XX XX of the XX with moderate XX XX changes

with XX XX XX and XX XX. An MRI of the XX XX dated XXXX identified XX with grade XX XX, XX XX XX XX tXXear and XX tear of the XX XX.

The treatment to date included medications (XXXX), XX therapy, XX-XX steroid injection, and surgical interventions. XXXX had failed conservative management as well as a XX XX arthroscopy (arthroscopic XX XX and XX XX of the XX XX on XXXX).

Per a utilization review determination letter dated XXXX determined that the prospective requests for XX XX XX XX and XX days of inpatient hospital stay between XXXX were non-certified. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The patient does have XX evidence of XX XX with XX symptoms and exam findings. However, there was no documentation of the patient's XX XXXX, as increased XX poses elevated risks for post-operative complications. Furthermore, the note of XXXX indicates the patient underwent a steroid injection. The guidelines recommend an interval of XX months between injection and XX XX XX (XX) to help prevent infection. I made multiple attempts to contact the XX to garner additional information or exceptional circumstances. This was unsuccessful. Therefore, based upon the provided documentation, the request is not currently supported."

Per a utilization review determination letter by XXXX, the prospective requests for XX XX XX XX and XX days of inpatient hospital stay between XXXX were non-certified. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The specific subjective and objective clinical findings, as well as significant functional limitations, were still insufficient to necessitate the procedure. Most recent assessment had no documented stiffness, nighttime joint pain, and XX XX index. In addition, the patient received a XX XX steroid injection on XXXX. The guidelines indicated that surgery should be delayed at least XX months following any intra-articular corticosteroid injection due to the risk of infection. Clarification is needed regarding the request and how it might affect the patient's clinical outcomes. Clear exceptional factors could not be identified. As the medical necessity of the requested surgery was not established, the ancillary appeal request for XX days of inpatient hospital stay is also not warranted at this time." In addition to the letter, an addendum was documented indicating that "During the peer discussion, it was stated the patient had an XX done by a partner in the past, which did not help. The provider feels a XX is the only treatment that would help the patient at this point. The patient had multiple cortisone injections, with no relief. The provider stated XX months is sufficient between an injection and surgery. After this discussion , the patient had a steroid injection in XXXX, therefore, the request is not medically necessary as it has not been XX months."

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

The ODG supports the utilization of XX XX XX as an option for management of XX-XX XX after documented failure of conservative modalities. The previous utilization review as indicated

that deficits include lack of document a XX, no indication of functional deficits, and history of recent corticosteroid injection. In reviewing the documentation available for review, vital signs were documented on the XXXX designated doctor evaluation. Based on the XX and XX provided, XX would be calculated at XXXX. This note also indicated ongoing complaints of functional deficits including persistent pain and stiffness. Regarding the history recent corticosteroid injections, the prior injection was provided on XXXX. At the time of the most recent review (XXXX) the XX XX would be less than XX months out from injection but was rapidly approaching that date. While the ODG typically recommends at least XX months out from injection, current clinical literature indicates that the highest risk is within the first XX months. As the XX-month timeframe has now passed, and the other deficits previously identified have been documented in the clinical information available for this review, certification would be advised. Given the documentation available, the requested service(s) is considered medically necessary.

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

☐ 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
☐ 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 and Treatment Guidelines

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☐ Pressley Reed, the Medical Disability Advisor

☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters

☐ Texas TACADA Guidelines

☐ TMF Screening Criteria Manual

☐ Peer Reviewed Nationally Accepted Medical Literature (Provide a description)

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

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.