Independent Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (682) 238-4977
Fax: (888) 299-0415
Email: carol@independentresolutions.com

Date: 11/21/2018 1:43:31 PM CST

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Orthopaedic Surgery

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

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX. XXXX had immediate onset of pain and XX. XXXX was diagnosed with XX XX, XX XX pain, and XX XX pain. On XXXX was seen by XXXX for XX XX pain. It was noted that the pain was XX, XX, and XX since onset. The date of onset was noted as XXXX. The aggravating factors included lifting, carrying, pushing / pulling, range of motion, and weightbearing. The associated symptoms included XX, XX, and XX. XXXX stated that XX therapy, which XXXX had previously undergone, had not helped. XXXX was on modified duty at the time. On examination, there was XX of the XX XX and common XX origin (XX XX XX). The XX extension test was XX. The assessment included XX XX of the XX XX. XXXX documented that XXXX had failed conservative treatment for XX XX. XX injections were contraindicated for this condition. XXXX continued on restricted duty XX months after the onset of conservative treatment including failure to improve with nonsteroidal anti-inflammatory drugs, XX XX / XX, activity modification, and XX therapy exercise programs to increase range of motion and strength of the XX around the XX. XXXX would like to consider surgical release. MRI showed a XX of the XX XX origin. XXXX recommended open XX XX XX and repair. A XX XX-XX was completed by XXXX, documenting the diagnosis of XX XX. Per the form, XXXX was allowed to return to work as of XXXX with restrictions, which were expected to last

through XXXX. The restrictions included no pushing, pulling, grasping, squeezing, XX flexion / extension, reaching, or overhead reaching. It was noted that surgery was pending, and appeal had been filed by XXXX. An MRI of the XX XX dated XXXX, revealed mild common XX XX and XX XX XX (XX XX). There was XX change at the XX XX of the XX XX. An indistinct appearance of the XX XX XX was noted without adjacent soft tissue XX, suggesting XX injury. The treatment to date included medications (XXXX), XX therapy, steroid injections, XX XX / XX, and modified duty. Per a utilization review decision letter dated XXXX, the request for outpatient XX XX XX XX XX XX and XX of XX XX at XX XX as requested by XXXX was denied. Rationale: As per the Official Disability Guidelines (ODG), surgery for XX was recommended for chronic XX or XX XX as indicated below, after XX months of failed conservative treatment. A successful peer-to-peer call with XXXX designee on behalf of XXXX was made. The designee stated that XXXX understands that XXXX did not yet meet ODG recommendations having not yet had XX full months of conservative care. XXXX had XX XX, which had been treated with XX therapy, straps, nonsteroidal anti-inflammatory drugs (NSAIDS), and XX months of time. As such, the request for XXXX, outpatient, XX XX, open XX XX XX and repair was not medically necessary. Per a reconsideration review decision letter dated XXXX, the appeal request for outpatient right XX open XX XX XX and repair of XX XX at XXXX was not approved. Rationale: "According to the provided documentation, Official Disability Guidelines recommend surgery for chronic XX or XX XX. An MRI impression revealed mild, extensor XX and small partial XX (XX XX). XX changes at the medial aspect of the XX XX. Distinct appearance of the XX XX ligament without adjacent soft tissue XX, suggesting remote injury. There was XX of the XX XX and extensor origin. The patient had a positive XX XX test. There was normal and passive range of motion in XX, extension, pronation, and XX XX. There was no dislocation, laxity, or subluxation. There was a negative ligamentous instability test. The patient's motor strength was normal as well. The patient failed conservative therapy for XX XX. Steroid injections are contradicted for the patient's condition. There is no documentation the patient had XX months of compliance with non-operative management."

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

The ODG supports the use of operative intervention is an option for management of XX XX after at least XX months of conservative treatment. The documentation available indicates that the injured worker has exhausted conservative modalities to include therapy, medications, and activity modification. The document vision available indicates a small XX-XX tear on MRI with XX and findings consistent with XX XX XX. While the guidelines would recommend XX months of conservative treatment, further conservative interventions would not be supported by the guidelines and given the duration of the symptoms, progression to surgical intervention would be considered medically necessary and appropriate and deviation from the guidelines would be warranted in this case.
Given the documentation available, the requested service(s) is considered medically necessary and the request is overturned.

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

☐ 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

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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

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

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL