Core 400 LLC

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

XXXX XX XX
XX

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

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.

On XXXX in an orthopedic consultation. XXXX reported persistent pain in the XXXX XX with XX. XXXX other XX did not have any significant pain. XXXX continued to complain of pain and XX in XXXX XX. XXXX denied any significant pain in XXXX XX prior to the injury. XXXX had been seen at XXXX, had imaging studies performed and also had XX therapy. XXXX was on XXXX had been off work. On examination, XXXX was XXXX. XXXX ambulated on XXXX XX XX with an XX gait. There was XX XX XX. The XXXX XX had a trace XX. There was XX XX with some XX. XXXX had XX active extension with flexion to XX degrees. Extreme flexion caused pain. McMurray's test was negative. There was no gross ligamentous laxity and no XX tenderness. Light touch was intact, and there were good distal pulses. XXXX was not responding to nonoperative management and recommended a XXXX XX XX examination with treatment of XX-XX pathology as needed. In the meantime, XXXX would be on work restrictions.

An x-ray of the XXXX XX dated XXXX revealed early changes of XX of the XXXX XX, XX compartment. An x-ray of the XXXX XX demonstrated early changes of XX of the XXXX XX, XX compartment. X-rays of XX XX were normal.

An MRI of the XXXX XX dated XXXX showed intact XX. Findings suggested a XX-grade XX or stress response of the XX XX XX XX (XX). XX and XX XX ligament were intact. There was high-grade XX compartment XX XX, particularly involving the XX XX of the compartment. There was a XX XX XX of the XX XX XX. A XX low single XX XX was seen at the XX aspect of the XX XX, XX joint XX with mild XX, a thin XX XX, and nonspecific XX XX at the XX XX of the XX, there was a XX frank XX XX XX to the XX, suggestive of a small XX or XX XX.

The treatment to date included XX therapy, medications (XXXX), and modified work status.

Per a utilization review adverse determination letter dated XXXX, and a peer review by XXXX, the request for XXXX XX XX under general anesthesia, as an outpatient was denied. Rationale: "The Official Disability Guidelines state that XX XX XX surgery is recommended when the symptoms are consistent with a XX XX after the failure of conservative treatment. The patient had positive imaging evidence of a XX XX. The patient was also previously treated with therapy and medications. Although surgery may be warranted, the XX codes submitted were XX, XX, and XX. The CPT code XX is for an XX XX. It is unclear as to why the patient would require a XXXX XX XX in addition to an XX XX. Further clarification is needed. Therefore, the request as submitted is not supported. As such, the request for "XXXX XX XX under general anesthesia, as an outpatient" is not medically necessary."

Per a reconsideration review adverse determination letter and peer review by XXXX, the request for XXXX XX XX under general anesthesia, as an outpatient was not approved. Rationale: "The most recent progress note dated XXXX includes a XX examination of the XXXX XX rather than the XXXX. There are no specific abnormal XX examination findings of the XXXX XX that correlate with XXXX symptoms or imaging studies to support XX intervention. Considering this XX examination, this request is not medically necessary. I spoke with XXXX and designee, who stated that there were no injections found in the records. Extreme XX causes pain, it was stated. The patient does not fully meet the criteria per ODG guidelines. Main symptoms seem to be XX in nature. There were no discrete focal findings noted. XXXX symptoms, XX findings, and enhance imaging do not support the requested procedures above. Therefore, this request is not medically necessary."

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

The ODG recommends XX XX XX surgery (XX) where symptoms are noted consistent with a XX XX and after failure of conservative treatment. The available information reveals evidence of persistent XXXX XX pain and functional limitation approximately XXXX months out from injury despite treatment with activity modification, XX therapy, XXXX. There are XX examination findings of XX XX, XX, and pain with extreme flexion. There is an MRI finding of a XX cm XX XX XX in the XX aspect of the XX XX. Given the persistent symptoms despite appropriate conservative treatment and symptoms consistent with the documented XX XX on MRI, the XX XX XX removal (XX) is supported. This request also includes XX codes XX and XX which pertain to XX XX XX and XX. It is unclear why these codes are requested as there is

no evidence of XX pain or XX. Based on the provided documentation, the XX XX XX XX of the XX (XX) is medically necessary, but XX XX XX and XX (XX and XX) are not medically necessary. Recommendation is for partially overturning the previous denials with overturning the denial for CPT code XX but upholding the denials for CPT codes XX and XX.

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.