Becket Systems
An Independent Review Organization
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11/19/18

Description of the service or services in dispute:
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. The mechanism of injury was not found in the medical records. XXXX was diagnosed with a pain due to XX device, XX, initial encounter. (XX).

XXXX for worsening XX XX pain associated with XX and XX. XXXX was able to do activities of daily living with limitations at the time. XXXX described the pain as XX, XX and XX. The symptoms occurred constantly and were moderate in severity. They were exacerbated by motion at the XX and XX. On examination, the strength was XX/5 at the XX XX. There was limited range of motion, XX degrees to XX degrees of XX. XXXX documented that XXXX continued to have activity-limiting XX pain and motion loss as a result of the acquired XX XX of the XX. XXXX had failed conservative therapy and would likely require XX under XX to improve.

XXXX was re-evaluated by XXXX for the persistent worsening of XX XX pain. The symptoms were exacerbated with prolonged XX and XX. The examination remained unchanged from the prior visit.

A XX scan of the XX XX dated XXXX revealed the XX XX to be in XX alignment, without evidence of loosening, but with limited evaluation of the XX XX secondary to XX XX. There was a small XX joint XX with XX changes.

Treatment to date included medications, XX XX (total XX XX in XXXX)

Per utilization review determination letter dated XXXX denied the request for XX XX XX under anesthesia of the XX XX XX, with assistant, as outpatient between XXXX, as not medically necessary. Rationale: According to the Official Disability Guidelines, surgery is indicated with the patient who has had the appropriate conservative treatment and the patient had pain and functional limitations despite conservative management. The submitted documentation provided evidence that XXXX had pain and functional limitations despite conservative management. However, the submitted documentation did not provide evidence that XXXX had less than XX degrees of XX to greater than XX degrees of extension on examination. It was unclear, if XXXX had XX or a XX injection following the XX XX XX. As such, the medical necessity of the request was not established for XXXX. Based on the above documentation, the requested XX XX XX Under Anesthesia of the XX XX XX, with Assistant, as Outpatient was not medically necessary.

A reconsideration review letter dated XXXX indicated that the reconsideration request was denied / noncertified. Rationale: "Understanding this individual underwent a XX XX XX XX less than XXXX year ago, the physical examination presented indicating full extension at XX degrees of XX. Furthermore, the XX demonstrated no compromise to the surgical hardware. Lastly, it is not clear what, if any, conservative care was completed. In that there are no specific functional limitations to XX, range of motion is in excess of the parameters noted in the Official Disability Guidelines, there is insufficient objective clinical information presented supporting the need for this XX under anesthesia. This is not indicated."

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

The documentation provided indicates that the injured worker underwent a XX XX XX and XXXX and has ongoing complaints of pain, XX, and XX that interfere with activities of daily living. A physical exam documents XX/5 strength and range of motion of XX°. The provider indicates that the injured worker has ongoing XX XX pain XX to an acquired XX XX that is failed to improve with conservative therapy and is recommended XX under anesthesia. The XX under anesthesia has been denied secondary to the fact that there is no clear documentation regarding what conservative treatments have been failed and XX greater than XX°. Based on the documentation provided, the prior denial should be upheld in the XX under anesthesia would be considered not medically necessary as the injured worker is noted to have XX° XX and no documentation to indicate a trial and failure of a joint injection, XX, or XX therapy. Additionally, XX was noted to be more than XX months ago.

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 XX XX 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

XX and XX Chapter

XX under anesthesia:

XX

☐ 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 XX 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.