True Decisions Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 4/22/2019 4:36:58 PM CST

True Decisions Inc.

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IRO REVIEWER REPORT

Date: 4/22/2019 4:36:58 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 1. XX XX arthroscopy with XX, XX XX excision, extensive debridement, loose body removal, XX repair, XX, XX XX, possible XX, and possible XX XX repair 2. XX XX XX (purchase)

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

XX XX arthroscopy with XX, XX XX excision, XX repair, possible XX, and XX XX XX (purchase) x 1 is medically necessary and the decision is overturned but extensive debridement, loose body removal, XX, XX XX, and possible XX XX repair is not medically necessary and the decision is upheld

PATIENT CLINICAL HISTORY [SUMMARY]: XX. XX XX is a XX-year-old XX with a date of injury XX when the XX XX XX XX XX XX, resulting in XX to XX XX XX. XX was diagnosed with XX XX of the XX XX, XX XX and XX XX XX from the XX o'clock to XX o' clock position, XX XX XX XX XX (XX) lesion, XX XX, XX joint XX, and tear of XX XX XX. On XX, XX. XX was evaluated by XX / XX for follow-up on recurrent XX XX pain. The pain was aggravated by overhead activity and lifting. The associated symptoms included muscle weakness and painful range of motion. The examination showed XX-XX impingement,

impingement, XX XX differentiation, and XX impingement tests were positive on the XX side. The functional testing showed XX XX crossover adduction test, XX load test, XX test, XX test, XX test, XX test, Speed's test, XX test and XX test were positive. XX noted that XX. XX reported improvement from the XX injection at the prior visit but had recurrent episodes of dislocations. XX continued to have activity limiting XX pain and instability, which had not improved with conservative treatment including medications and XX therapy. At that point, XX felt XX. XX would likely not improve without surgical intervention. It was noted XX may return to work with restrictions of no lifting more than XX pounds. MRI arthrogram of the XX XX dated XX revealed XX intermediate signal seen undercutting the base of the antero-XX XX and adjacent XX XX, but the signal was not as bright as a XX solution, and the XX was not displaced. This was suspected to represent a XX or chronic XX of the XX-XX XX with mild stripping of the XX. Treatment to date consisted of medications (XX, XX, XX, and XX), XX injection in the XX XX, XX therapy, and modified duty. Per a utilization review determination letter by XX XX, XX dated XX, the request for XX XX arthroscopy with XX, XX XX excision, extensive debridement, loose body removal, XX repair, XX, XX XX, possible XX, possible XX XX repair, and XX XX XX (purchase) x1 was denied. Rationale: "Per evidence-based guidelines, surgery is indicated after provision of conservative care in conditions with pertinent subjective complaints and objective findings corroborated by imaging. XX had an ongoing XX XX pain, pain with overhead activity and lifting, muscle stiffness, swelling, weakness, and painful range of motion. Examination showed instability of the XX XX, popping on movement of XX, positive XX test, XX apprehension test, XX test, XX test, and XX test. However, there was no conventional films show either post-traumatic changes of XX joint or severe XX joint XX of XX joint, or complete or incomplete separation of XX joint and had no bone scan submitted that had a positive for XX joint separation. A significant functional impairment persisting at least XX XX was not yet established. There were no conventional x-rays (XX, and true lateral or axillary view), aside from MRI or arthrogram that showed positive evidence of XX (XX XX, XX XX XX, Type II or III XX) for extensive debridement / XX. There was a concurrent request for XX XX XX (purchase) in addition to XX XX Arthroscopy with XX, XX XX Excision, Extensive Debridement, Loose Body Removal, XX Repair, XX, XX XX, Possible XX, and Possible XX XX Repair. The surgery is not indicated at this time which obviated the medical necessity of the ancillary request." A letter by XX XX, X dated XX, indicated that the reconsideration request was 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. There was still limited subjective and objective clinical findings presented to warrant the need for surgery. The imaging report did not show evidence of impingement, post-traumatic changes of the XX joint, a severe XX joint XX of XX joint, incomplete separation of XX joint, and consistent recurrent XX / XX. Moreover, objective evidence of exhaustion from adequate conservative treatment was not fully established. The guidelines indicated there should be at least XX months of conservative therapy prior to necessitating surgery. There were no additional medicals noting significant objective changes in the medical records submitted to overturn the previous denial of the request. The prior noncertification is upheld. Furthermore, during the peer discussion with XX, XX and designee, the provider stated that the diagnosis for the XX is XX tear, XX XX of the XX. X-rays shows a type II XX and some XX joint XX, pain with crossover test, which was the need for the XX XX excision. They have had up to XX dislocations. Back in XX, the patient had XX therapy, XX injection in XX because of stiffness noted at the first exam. The patient noted relief with the injection. The MRI findings were discussed. After this discussion, the patient has a clear XX issue, however, it is unclear the need for XX XX, XX XX excision or XX XX. No agreement for partial certification could be reached as the XX cut the conversation short, therefore, the entire request remains not medically necessary. The concurrently requested surgery is not substantiated, which precludes the need for XX XX XX (XX) x1 XX."

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

The ODG does not recommend surgery for XX syndrome as an isolated procedure and recommends at least XX XX conservative treatment unless earlier surgical criteria are met for other associated XX diagnoses. The ODG

recommends XX XX excision following a failure of XX weeks of conservative treatment when there are objective findings of symptomatic XX joint pathology and imaging findings of degenerative changes of the XX joint. The ODG recommends arthroscopic debridement for XX joint XX and loose body removal as an alternative to arthroplasty when there has been a failure of the XX months of conservative treatment including NSAIDs, intra-articular XX injections, and XX therapy. The ODG recommend surgery for XX dislocation following a failure XX months of conservative treatment, chronic instability, positive provocative testing, and imaging findings consistent with recurrent dislocation/instability. The ODG does not recommend thermal XX. The ODG recommends XX XX for the treatment of XX XX or superior XX tears following XX to XX months of failed conservative treatment including NSAIDs, injection, and XX therapy. The ODG recommends XX XX repair for partial-thickness or small full-thickness XX XX tears following a failure XX to XX months of conservative care when there is evidence of an at least partial deficit in the XX XX on imaging. The provided documentation indicates the patient had persistent XX XX pain and instability approximately XX months out from injury despite treatment with activity modification, NSAIDs, XX therapy, and a XX injection. The injection provided temporary relief. There are physical examination findings of positive XX testing, a positive XX XX crossover adduction test, a positive XX load test, positive XX test, a positive XX test, a positive XX's test, a positive SLAP prehension test, positive speeds test, a positive XX test, and a positive XX's test. There are x-ray findings of a type II XX in XX to XX There are MRI arthrogram findings of a type II XX, and XX XX tear, intact XX XX tendons, intact XX had XX tendon, and no significant muscular XX or atrophy. As there has been a failure greater than XX weeks of conservative care, there is a positive XX crossover adduction test on physical examination, and there imaging findings of XX joint XX on x-ray, XX XX excision is supported. As there is evidence of objective XX on physical examination, XX anatomy on x-ray and MRI, and criteria for other associated XX diagnoses are met, XX is supported. As there is no evidence of XX joint XX or loose body, extensive debridement and loose body removal are not supported. As there is evidence of chronic instability despite XX months of appropriate conservative treatment with objective instability on examination and an XX XX tear on MRI, the XX repair and possible XX are supported. As there is no evidence of XX or superior XX pathology on MRI, XX XX is not supported. As there is no evidence of a partial or full thickness XX XX tear on the MRI arthrogram, the possible XX XX repair is not supported. As XX surgery is supported, the XX XX XX is supported.
Based on the provided documentation and ODG recommendations, recommendation is to partially overturn the XX previous denials with certification of XX XX arthroscopy with XX, XX XX excision, XX repair, possible XX, and XX XX XX (purchase) x 1 is medically necessary and the decision is overturned, but extensive debridement, loose body removal, XX, XX XX, and possible XX XX repair is not medically necessary and the decision is upheld.

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

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☐ 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

ODG, 2019: XX