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IRO Certificate #XX

DATE OF REVIEW: 04/01/19

IRO CASE NO. XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
XX XX Arthroscopy, Partial XX XX, Outpatient, XX, XX, XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified in Orthopedic Surgery

REVIEW OUTCOME

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

Upheld	**(Agree) X**
Overturned	(Disagree)
Partially Overturned	(Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY
XX XX arthroscopy, partial XX XX, outpatient, has been non-certified as being medically unnecessary. An appeal review performed XX for XX XX arthroscopy was also denied as being medically unnecessary.

Office note dated XX by XX reports patient is post op XX XX arthroscopic, partial XX XX, XX. Patient reports pain on XX side of his XX XX beginning XX with no known injury. Physical examination showed healed arthroscopic portals. Patient underwent a XX XX intra-articular steroid injection.

Patient seen XX by XX for XX. Complaint is XX XX pain. Patient was started on XX XX Pack and an analgesic. Physical examination showed XX lateral XX XX tenderness and a positive X test. X-rays of the XX XX were performed, report states no acute findings. Patient was scheduled for another MRI of the XX XX.

Patient again seen on XX by XX

Physical examination showed tenderness along the XX XX XX and a positive XX test. XX had no laxity. The MRI report was discussed.

MRI of the XX XX performed without contrast, XX, by XX, with an addendum by XX, XX, shows a large radial XX of the XX XX XX XX, indeterminant in

PATIENT CLINICAL HISTORY SUMMARY (continuation)
age, with tear of the XX XX component of the deep XX XX appearing acute, large areas of XX within the XX XX and XX XX which appear chronic. XX is noted to have thinning of the articular surface of the XX XX XX and grade 1 XX in the XX XX.

MRI of the XX XX performed XX shows post-surgical changes of XX XX. There is a XX mm XX fragment extending into the inferior XX gutter with concern for a new flap tear involving the body of the XX XX. There is interval decrease in edema in the XX extension in the deep portion of the XX. There is interval worsening of large areas of XX involving the XX XX XX with XX flattening and subcontractor XX and further progression of XX.

Office note dated XX by XX reports XX XX pain. No assessment rendered in the note.

Office note dated XX by PA-C reports XX XX pain. Physical examination shows XX joint line tenderness and positive XX test. MRI report was discussed. Plan was to perform XX XX XX with partial XX XX.

Summary of events: XX year old XX sustained work injury of the XX XX in XX, XX, underwent XX XX arthroscopy XX. Patient had recurrence of pain in XX without interval injury. Exam shows XX joint line tenderness and a positive XX test. Repeat MRI shows a XX mm under surface tear of the XX XX, post surgical changes of the XX XX and diffused XX XX of the XX XX and XX XX with progression of XX XX XX XX clumps and XX. Patient has failed to improve despite treatment with intra-articular steroid injections, anti-inflammatories, and modified activities.

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

Opinion: I agree with the benefit company's decision to deny the requested service of XX XX arthroscopy with partial XX

Rationale: In my opinion, a second XX XX arthroscopy to remove the under surface tear of the XX XX would be unlikely to improve the patient's pain. The pain appears to be related to the XX XX with collapse of the XX XX XX and X XX side of the XX. **This condition would not benefit from another arthroscopy.**

The denied service would not benefit patient and is not medically necessary.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION (continuation)

MIILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

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