IRO Express Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 4/15/2019 5:11:06 PM CST

IRO Express Inc.

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IRO REVIEWER REPORT

Date: 4/15/2019 5:11:06 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX open XX XX surgery

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]: XX. XX XX is a XX-year-old XX who was injured on XX while XX a XX to XX XX until the XX in the XX XX. The diagnoses included strain of muscle, XX, and tendon of other parts of XX, XX XX, initial encounter (XX.XX) and pain in XX XX (XX.XX). XX. XX was seen by XX XX, XX on XX and XX for the post-operative visits for open XX XX. On XX, XX returned for a postoperative visit. XX had undergone open XX XX XX of the XX XX on XX. XX stated that XX had mild postoperative pain. XX was recovering at home. XX had been receiving XX therapy and pain medications. On examination of the XX XX XX, XX had diffuse tenderness and diffuse swelling over the XX. There was decreased range of motion secondary to pain. The strength tested was limited secondary to pain. There was generalized XX about the XX XX. XX, XX. XX reported mild postoperative pain. XX was doing “okay” at the time and

reported some achiness in XX XX XX. XX had been using XX for most of time. The XX XX XX examination showed mild tenderness over the operative site and occasional tenderness over the XX. Diffuse weakness was noted. XX. XX opined that XX. XX could return to work with the restrictions. An MRI of the XX XX dated XX showed complete XX of the XX long XX of the XX tendon with retraction to the XX XX XX. XX had XX low grade, partial thickness, and partial width XX of the XX tendon. X-rays of the XX XX dated XX revealed mild XX changes of the XX XX joint. There were moderate changes in the XX XX joint. X-rays of the XX XX / XX dated XX showed no arthritis and XX distance was maintained. There were no soft tissue abnormalities and no bony lesions. The treatment to date included medications (XX which was helpful), XX therapy, a XX, and surgery including XX open XX XX XX on XX. Per a utilization review decision letter dated XX, the request for XX open XX XX XX was denied by XX, XX. Rationale: “Official Disability Guidelines did not recommend surgical treatment tor an acute XX of the XX XX noting XX is not recommended as a stand-alone treatment. At this time, with the patient’s pain decreasing, there is no support to deviate from guideline recommendations. The request is not certified.” Per a utilization review decision letter dated XX, the prior denial was upheld by XX, XX. Rationale: “Although this patient is only XX years old. This injury occurred only XX weeks ago, and there is no mention of any conservative treatment with any XX therapy or exercise program which may improve XX symptoms. Accordingly, this request is not medically necessary and non-certified.”

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

The ODG recommends XX XX for ruptured XX tendons in patients under the age of XX following XX months of failed conservative treatment including NSAIDs, injection, and XX therapy unless combined with acute XX XX repair. The provided documentation indicates the injured worker sustained a long XX XX XX XX that was treated with open XX XX on XX. The notes prior to surgery indicate symptoms are improving with over the counter medications. There is no evidence of a treatment failure with XX therapy or injection. There is no evidence of significant functional limitation due to the long XX XX tendon rupture. Based on the provided documentation and ODG recommendation, the XX open XX XX surgery dated XX is not medically necessary. Recommendation is for upholding the XX previous denials.
Given the documentation available, the requested service(s) is considered 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:

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG, 2019: XX; Surgery for XX XX (or XX)