Core 400 LLC

An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

Reverse total XX XX arthroplasty

XX	Arthroplasty, XX joint; total XX {XX and XX XX replacement (eg, total XX)}
XX	XX of long tendon of 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)

XX. XX XX is a XX-XX-dominant XX-year-old XX who was injured on XX. XX sustained a XX XX injury while XX XX-XX XX and XX pain and a pop. XX was diagnosed with XX pain, XX syndrome, XX XX XX tear, XX strain, XX (XX) joint sprain, and XX XX.

On XX, XX. XX was evaluated by XX, XX for XX XX pain. The pain was rated at 2/10 at rest and 8/10 at worst. XX reported numbness / tingling, popping / clicking, XX XX, and weakness. There was painful overhead motion, reaching behind XX, and at XX. XX affected area XX 10% normal. Examination of the XX XX showed no obvious deformity / sign of infection. The range of motion was 110 degrees with forward flexion, 33 degrees with external rotation. The abduction and forward flexion were weak. There was tenderness at the XX. XX sign, painful arc, Speed test, crossbody test, and O'Brien's test were positive.

An MRI of the XX XX dated XX showed XX joint XX narrowing the XX space, unusual XX of the XX and XX anterior XX XX with diffuse high XX XX XX XX within the XX XX and localized about the XX XX repair suture XX, surgical implants within the XX XX. Findings might be compatible with pathologic or stress fracture positive XX XX XX could be possible. There was residual or recurrent XX-thickness tear in the XX XX tendon measuring XX mm in length. The XX XX tendon could not be assessed, however, within the XX XX groove there was XX tendon XX. X-ray of the XX XX dated XX showed no fracture, no dislocation, hooked anterior XX, and visualized XX field was clear.

The treatment to date included medications (XX), XX therapy, XX XX, and status post XX XX XX XX repair, XX decompression, and XX XX on XX. XX. XX had failed all conservative treatment.

Per a utilization review decision letter dated XX, the request for reverse total XX XX XX was denied by XX XX, XX. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is noncertified. Most recent medical records submitted for review had limited documentation of significant

objective findings to warrant the requested surgery. There was also no clear documentation if the patient had failed conservative management such as nonsteroidal anti-inflammatory drugs, intra-articular steroid injections, and XX therapy for at least XX months supported by objective or clinical findings before considering another surgery. In addition, guidelines do not recommend reverse XX XX if there was an irreparable XX XX tear. The exceptional factors were not identified."

Per an adverse determination letter dated XX, the prior decision was upheld by XX. 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. During the peer discussion, it was stated the patient had a XX XX, with the injury over a XX ago. The patient had delayed treatment, and therefore, had poor success of healing. The repair failed, and recent MRI still showed a XX XX. The patient is not a XX, per the provider. The provider is also not worried about infection, as labs are negative. Aspiration was denied as well. The patient has severe pain, and a positive drop XX. After this discussion, the patient is XX, with no definite XX description, and this surgery is not indicated in that population, therefore, the request for reverse total XX XX XX is not supported."

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

In review of the provided MRI study, there was a recurrent and large XX thickness XX at the XX XX XX XX. The claimant had not improved with non-operative measures to date. Given the size and extent of the recurrent XX XX XX, a revision of the prior repair is not likely to be successful. The claimant would not reasonably improve further with non-operative measures. As such, it would be reasonable and standard of care to proceed with a reverse XX XX to salvage some functioning of the XX XX and to reduce pain. Given the documentation available, it is this reviewer's opinion that medical necessity is established and the prior denials are overturned.

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
  XX (XX)
  XX
- ☐ Pressley Reed, the Medical Disability Advisor

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- ☐ 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.