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Date notice sent to all parties: 02/15/19

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX XX arthroscopy, XX procedure, decompression of XX space, XX XX repair, and XX XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified in Orthopedic Surgery
Diplomate of the American Board of Orthopedic Surgery
Fellow of the American Academy of Orthopedic Surgeons
Fellow of the American Association of Orthopedic Surgeons

REVIEW OUTCOME:

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

☐ Upheld (Agree)

☐ Overturned (Disagree)

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

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

XX XX arthroscopy – Overturned
Decompression of XX space – Overturned
XX XX repair - Overturned
Mumford procedure – Upheld
XX XX – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was evaluated at XX on XX for XX XX pain and tingling and numbness in the XX XX. XX rated the pain at 10/10. It appeared XX was XX a XX XX and XX XX. It appeared XX was diagnosed with a XX XX sprain. Additional reports were provided from XX. A XX XX MRI was obtained on XX and revealed the XX XX mm of the XX tendon demonstrated approximately 20% partial thickness tearing. There was a high grade 80% thickness surface and XX XX within the posterior half of the XX and the anterior half of the XX. Within the area of 80% thickness partial tearing was a small XX full thickness XX measuring approximately XX mm. There was a XX joint effusion and XX/XX XX. It was also noted a source for XX XX impingement was significant XX XX downsloping. XX examined the patient on XX. XX noted XX lifted a XX XX of XX with XX and XX a XX in the XX XX and XX. XX pain complaint now was pain in the XX XX and XX. XX had normal ROM of the XX, but it was painful. The XX XX had full ROM and XX had anterior XX and XX groove tenderness. XX's and XX's were positive. The MRI was reviewed and XX injection was performed at that time. XX would be referred for therapy. XX was then evaluated in XX therapy on XX and XX would receive treatment XX times a week for XX weeks. On XX, the patient noted the steroid injection did help, but when XX lifted XX XX, XX had pain. XX XX flexion was 20 degrees, extension and internal rotation were 0 degrees, abduction was 50 degrees, and external rotation was 30 degrees. Therapy and medications were continued. As of XX, XX had had XX injections with immediate pain relief, but eventually the pain would return.

Flexion was 80 degrees, extension was 30 degrees, internal rotation was 0 degrees, and extension and external rotation were 70 degrees. XX had first XX compartment tenderness and XX's was positive. A first XX compartment injection was done and therapy was continued for the XX. On XX, XX recommended XX XX surgery, which XX provided an adverse determination for on XX. The patient followed-up with XX on XX and had 60 degrees of flexion, abduction, and external rotation. Extension was 20 degrees and internal rotation was 50 degrees. XX's and XX's were positive. XX press was positive and XX could not perform lift off due to motion and pain. It was noted XX had received XX injections and XX sessions of therapy and had failed conservative treatment. Surgery was again recommended and XX returned to XX on XX. XX continued to have symptoms despite conservative care and XX again noted the patient was a surgical candidate. On XX, XX provided another adverse determination for the requested XX XX surgery.

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

The patient is a XX-year-old XX who reportedly developed XX XX and XX XX pain after XX a XX of XX with a XX at XX on XX. A XX XX MRI scan on XX reported a 20% partial thickness XX of the XX XX mm of the XX, 80% partial XX of the posterior half of the XX, 80% partial XX of the anterior half of the XX, a XX XX mm

full thickness XX, no XX XX atrophy, significant XX XX downsloping with XX effusion, and XX XX. The patient was subsequently referred to orthopedic surgeon, XX, and was treated with XX therapy, medications, and multiple XX injections. The patient, despite treatment, continued with XX XX pain and XX has recommended the requested surgical procedure, as documented in XX request.

The ODG treatment criteria for XX

The ODG indications for surgery XX

The patient is a XX-year-old XX who appears to have failed conservative care as recommended by the ODG. Unfortunately, XX treating provider has recommended a XX procedure and XX XX, which are not supported. Both plain films, as well as MRI scan, did not document any significant evidence of XX joint pathology or significant XX tearing, XX, or dislocation. XX noted in XX reconsideration/appeal that XX would have certified the request if these additional procedures were not included, but XX was not able to speak to the treating provider. The proposed surgical procedures as requested does not meet the ODG criteria since there does not appear to be a medical indication or necessity for the XX procedure or XX XX. The previous adverse determinations for these two procedures should be upheld. However, the requested XX XX arthroscopy, decompression of the XX space, and a XX XX repair are medically necessary and supported by the evidence based ODG Therefore, the previous adverse determinations for these three procedures should be overturned at this time.

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**

☐ **AHCPR- 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**

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

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ **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 A DESCRIPTION)**

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