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IRO REVIEWER REPORT

Date: 2/19/2019 2:15:07 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX total XX arthroplasty with XX XX stay

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 sustained a work-related injury to XX XX XX on XX. The injury was caused by XX and XX. XX felt a XX and XX. XX was diagnosed with XX of the XX XX, complex XX of the XX XX XX, and sprain of other specified parts of the XX XX. On XX, XX. XX visited XX for a follow-up of XX XX pain, sprain, XX, and “XX” after XX. XX reported XX had completed XX therapy with minimal relief, and stated the hinged XX XX stabilized the XX. XX symptoms continued to be aggravated by going up the stairs, kneeling, squatting, standing, and walking. XX reported that XX symptoms were aggravated over the prior weekend. XX pointed to the medial and anterior XX. XX was using XX, XX, and had completed XX injections. XX XX examination revealed tenderness of the medial XX and pain with range of motion. The diagnoses were contusion of the XX XX, XX primary XX of the XX XX, complex XX of XX medial XX, and sprain of other specified parts of the XX XX. XX assessed that XX. XX had failed the XX series and completed XX therapy. A surgical consultation was provided. XX. XX was evaluated by XX on XX. XX presented with complaints of pain and non-painful clicking or triggering in the XX XX. XX. XX had XX and XX while XX on XX. XX symptoms were aggravated by daily activities, walking, and twisting. XX stated nothing relieved XX symptoms. Prior

treatment included XX, XX injections, and gel injections, which failed to relieve the symptoms. The symptoms were worse with activity. XX reported XX with a XX. XX XX examination revealed tenderness over the medial XX and pain with range of motion. The diagnosis was XX primary XX of the XX XX. XX assessed XX XX pain secondary to exacerbation of XX after XX at XX and pain since XX, refractory to conservative treatment. He recommended weightbearing as tolerated and a XX total XX arthroplasty. An MRI of the XX XX was completed on XX for XX XX pain after injury. The study demonstrated severe XX, most significant in the XX compartment, where there was degenerative XX of the medial XX and severe, full-thickness grade 4 cartilage XX. A small-sized XX joint effusion was noted with a large-sided XX. Treatment to date included medications, XX, XX therapy, steroid injections, and XX. In a utilization review decision letter and a peer review dated XX, XX denied the request for a XX total XX arthroplasty. Principal reasons for the determination were as follows: “As per ODG ‘XX’ As per ODG, ‘XX’ This is a XX-year-old who sustained an injury on XX. The patient has persistent XX XX pain. Examination revealed tenderness over the medial XX with painful range of motion (ROM). Non-operative treatment in the form of XX therapy, medications, XX, injections and activity modifications has been tried and failed. However, there are no standing x-rays submitted, and the BMl is not documented. A successful peer-to-peer call with XX was made at XX. The details of the request were discussed, and the results of that discussion are documented below. We discussed clinical details, associated guidelines and appeal potential if deemed at all applicable. The XX reiterated the clinical findings and failure of XX, injections and XX therapy. Therefore, this request is not medically reasonable and necessary at this time.” Per a utilization review decision letter and a peer review by XX dated XX, the request for a XX total XX arthroplasty (XX) with XX-XX stay was noncertified as not medically necessary. Rationale: Per Official Disability Guidelines, “Body mass index (BMI) less than XX, as increased BMI poses elevated risks for post-op complications. {Pre-operative bariatric surgery is not supported but may be otherwise indicated for unrelated medical (disease of life) reasons}.” XX. XX’s complaints and examination findings were consistent with severe osteoarthritis of the XX. XX had failed conservative treatment including XX, XX injections, XX therapy, and gel injections. A total XX replacement would be indicated; however, the records did not document an appropriate body mass index, and Official Disability Guidelines did not recommend a total XX arthroplasty for a patient with a body mass index greater than XX. Therefore, the request was not certified.

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

In review of the provided records, there is evidence of severe XX that had not improved with conservative treatment to include injections, XX therapy, and medications. The records submitted for review did not include a recent orthopedic evaluation of the claimant. The last evaluation was from XX which noted painful range of motion of the XX XX but no significant deficits. There was also no recent BMI documented for the claimant.

Without additional updated clinical information to support the surgical request, it is this reviewer’s opinion that medical necessity is not established and the prior denials are 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

☐ 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