US Decisions Inc.

An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

XX XX XX, modified XX, and XX XX / repair
XX - XX, XX (XX and XX joints), surgical; XX, partial
XX - XX, XX (XX and XX joints), surgical; debridement, extensive
XX - Repair, secondary, disrupted XX, XX, XX (e.g. XX procedure)
XX - XX, XX or XX XX, XX and/or XX; single, each XX

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Orthopedic Surgery

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations

- [x] Overturned (Disagree)
- [ ] Upheld (Agree)
- [ ] Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XX. XX XX is a XX-year-old XX who injured XX XX XX when XX XX on XX. XX also injured XX XX XX at that time. XX was diagnosed with XX XX, XX XX and XX (XX.XX); other instability, XX XX (XX.XX); sprain of other XX of XX XX, initial encounter (XX.XX); and XX of unspecified XX of XX XX, initial encounter (XX.XX).

Per an office visit note by XX dated XX, XX. XX presented for a follow-up of XX XX XX injury. XX had been lost to follow-up since XX. XX continued to complain of pain and XX. XX had been exercising on XX own. XX took XX XX for pain and continued to use an XX XX. Examination of the XX XX revealed XX to XX on XX XX XX XX with an XX XX. There was XX around the XX XX and XX XX. There was some XX in this area. There remained XX to XX drawer testing. The diagnoses of XX XX instability and XX XX XX were continued and an additional diagnosis of XX XX XX was added. XX. XX assessed XX. XX condition was unchanged. XX was clearly not responding to nonoperative management. XX. XX was to continue with XX support, anti-inflammatory medication as needed, and a home exercise program. Surgical intervention was recommended to include a XX XX XX, modified XX procedure, and XX XX repair for XX pain and instability.

On XX, XX. XX reported XX did not like taking pain medication. XX continued to complain of significant pain and instability. XX had been working. XX noted that XX prior request for surgical management was denied until XX had XX XX of XX XX (although XX XX were not routinely needed for XX problems). XX examination showed XX. XX to be XX on XX XX XX XX with an XX XX in an XX XX. There

remained XX at the XX and XX aspect of the XX. There was some XX. There was XX to XX XX XX. There was decreased XX range of motion due to pain.

An XX of the XX XX on XX revealed a high-grade XX XX XX. X-XXs of the XX XX obtained on XX demonstrated no evidence of fracture, XX XX, or other significant XX abnormalities. XX x-XXs of the XX XX on XX revealed significant XX translation of the XX on the XX view.

Treatment to date included physical therapy, XX XX, medications (XX, XX, muscle relaxer), steroid injection which helped the pain XX%, and light / modified duty work status.

Per a utilization review dated XX and a peer review by XX on the same date, the request for XX XX XX, modified XX, and XX XX / repair was not medically certified with the following rationale: "According to the Official Disability Guidelines XX and XX Chapter, a XX XX reconstruction is indicated for individuals who have complaints of XX pain and instability, as well as identified XX on imaging studies and failure to improve with conservative care. Imaging studies should also include stress x-XXs objectively identifying XX XX and minimal XX joint changes. Although this patient complains of XX instability and there is a positive XX drawer sign on physical examination, no XX XX have been provided with evidence of XX XX. Considering the absence of this objective information this request is not medically necessary and it is not certified."

Per a utilization review dated XX and a peer review by XX on the XX, the request for appeal XX XX XX, modified XX, and XX XX / repair was denied as not medically necessary. Rationale: "ODG supports the utilization of surgical intervention is an option for management of XX sprains. Based on the documentation available, the claimant meets the criteria for conservative care, subjective complaints, and objective findings. However, the claimant does not have documented XX XX of the XX. The XX XX are recommended by ODG and have also been advised by the AP based on the evaluation completed on XX. When noting the ODG requirement and the recommendation by the designated doctor, progression to surgical intervention would not be supported until XX XX have been completed. As such, the request is not supported at this time. Therefore, the request for APPEAL XX XX XX, modified XX, and XX XX / repair is not medically necessary."

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

Based on the documentation available for review, I would recommend overturning the prior denials. Both reviewers previously utilized the ODG which requires XX XX prior to surgical intervention for management of persistent XX XX. At the time of both reviews, XX XX were not available. Following the two previous reviews and recommendations for XX XX, these images were obtained on XX. The XX XX demonstrate significant XX translation of the XX on the XX view. Given the instability documented on XX XX, the ODG criteria would now be met, and overturn of the prior denials is recommended given the additional documentation submitted for this review. Given the documentation available, the requested service(s) is considered medically necessary.

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
- ☐
- ☐

Case Number: ***XX*** Date of Notice: 01/28/19

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

☐ Pressley Reed, the Medical Disability Advisor

☐ 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.