Pure Resolutions LLC

Notice of Independent Review Decision

Case Number: XX Date of Notice: 2/12/2019 3:49:46 PM CST

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IRO REVIEWER REPORT

Date: 2/12/2019 3:49:46 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX Arthroscopy with XX XX Repair with XX Decompression

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 an injury on XX while XX was XX the XX of a XX and injured XX XX XX. XX was diagnosed with complete XX XX tear or rupture of XX XX, not specified as traumatic (XX). XX. XX was evaluated by XX on XX for XX XX pain. XX had been seen before by XX under XX. XX requested waiting for surgery until the XX months when XX work was not as busy. It was discussed with XX at that time about concerns of retraction, etc. with waiting, but XX elected to wait. XX presented for a preoperative visit. On XX XX examination, there was tenderness of the greater XX and the lateral XX insertion. The empty can sign was positive, with pain and weakness. Strength in XX external rotation at 0 degrees of abduction was 4/5 and at 90 degrees of abduction 4/5. Strength in abduction was 4/5 and in flexion 4/5. An MRI of the XX XX dated XX was reviewed and revealed full-thickness anterior XX tear, partial XX tear, and XX XX without impingement. An MRI of the XX XX performed on XX showed a full-thickness insertional tear of the

anterior XX tendon fibers; partial-thickness articular surface tear of the distal XX tendon; XX without tear; and mild XX joint XX with small XX / XX. Treatment to date included medications (XX with minimal relief, XX-XX, XX, XX) and physical therapy. Per a utilization review letter and peer review dated XX by XX, the requested service of XX XX arthroscopy with XX XX repair with XX decompression was noncertified. Reason for determination: "Per evidence-based guidelines, surgery is recommended for patients with significant subjective complaints and objective findings corroborated by imaging report and after exhaustion of conservative care. However, the pertinent subjective complaints and objective findings presented were limited to warrant the need for surgery. Also, given the date of the injury (XX), exhaustion of all conservative treatments duration of at least XX could not be established. An exceptional factor was not identified. Furthermore, I spoke with XX, who stated the patient had therapy, XX, with no injections. The provider was concerned about the tendon if they got an injection. The tear is full thickness, it is stated, and disagrees with the radiologist. The patient requested to wait till after their XX XX to have surgery. After this discussion, the patient has not had an injection, and also there is a discrepancy between the radiologist read and the provider, therefore, the request is not medically necessary. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. The erroneous records were not used in making the determination." A letter dated XX by XX documented that XX was treating XX. XX for XX XX XX full-thickness XX XX tear. XX. XX initially visited under XX on XX. Based on XX examination, XX ordered an MRI of the XX XX. This was completed on XX. It was read by the radiologist as a partial XX XX tear. However, when reviewing the images, it was clear that there was a full-thickness perforation tear, which would not heal with nonoperative management. XX, therefore, never recommended formal physical therapy or steroid injections, as these would not be of benefit. After discussing this with XX. XX, XX wished to wait until the end of XX XX XX at work and have the surgery in the winter. XX then saw XX. XX back pre-operatively and recommended surgery and attempted authorization. This was denied due to the radiology reading as a partial tear, but again, XX opined this was incorrect. This case needed reconsideration, as again, per XX. XX, this was a full thickness tear that needed surgery and would not get better without it. Per a reconsideration adverse determination letter dated XX by XX, the requested service of appeal XX XX arthroscopy with XX XX repair with XX decompression was noncertified as it did not meet the medical necessity guidelines. Reason for determination: "Per evidence-based guidelines, surgery is indicated in patients with pertinent subjective complaints and objective clinical findings corroborated by imaging studies after the provision of conservative care. An appeal request for XX XX arthroscopy with XX XX repair with XX decompression XX XX was made; however, the specific objective clinical findings, as well as significant functional limitations, were still insufficient to fully necessitate the request. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. There was no pain with active arc motion and pain at night. There was also no temporary relief of pain with anesthetic injection. The MRI of the XX XX without contrast dated XX documented full thickness insertional tear of the anterior XX tendon fibers and partial-thickness XX surface tear of the XX XX tendon. Given the date of injury on XX, adequate compliance, exhaustion, and failure from indicated conservative treatments could still not be established. Clarification is needed regarding the request and how it might affect the patient's clinical outcomes. Clear exceptional factors could not be identified. Furthermore, during the peer discussion with XX. XX, the provider stated that this is not an appeal. The patient wanted to wait until the end of the XX XX. The radiologist read a XX tear, and the provider sees a full XX XX on the images. The provider then thought PT and injections would not be indicated. The patient was XX-XX weeks ago, same weakness, no improvement. There is night pain and activity pain. The patient does not fully meet the criteria per ODG. There is also a question of the MRI read, as the provider states there is full XX XX, XX XX XX require XX months of conservative care. There has not been full exhaustion of all conservative measures, to include injection therapy, or physical therapy, therefore, all above requests are not medically necessary."

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

The provided records noted an insertional XX XX XX of the XX tendon with XX XX of the XX. The records did not document failure of reasonable conservative treatment. There was also no recent orthopedic evaluation of the claimant

noting any significant objective findings that would reasonably support proceeding with surgical intervention.

Given these issues, 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

See also Surgery for impingement syndrome; Continuous passive motion (CPM); XX™ -- XX XX repair