AccuReview

An Independent Review Organization
569 TM West Parkway
West, TX 76691
Phone (254) 640-1738
Fax (888) 492-8305

[Date notice sent to all parties]: February 19, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX XX Scope with XX XX, XX XX, XX XX, and XX tendon XX XX XX XX XX

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

This physician is Board certified in Orthopaedic Surgery with over 17 years of experience.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

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

PATIENT CLINICAL HISTORY [SUMMARY]:
XX: Office Visit dictated by XX. CC: claimant was XX XX to put XX in XX, and something XX in XX XX. Taking XX and XX. Reported throbbing. Requesting MRI of XX XX. DX: XX XX sprain/strain.

XX: MRI XX XX XX (XX) WO Contrast XX dictated by XX. Impression: 1. Healed posttraumatic and postsurgical appearance of the XX and XX. 2. XX degeneration of the XX and posterior XX. 3. XX XX XX with suspected low-grade interstitial XX involving the contribution of the XX.

XX: Office Visit dictated by XX. CC: XX XX pain, improved with rest, elevation and XX. Approved for PT.

XX: History & Physical dictated by XX. CC: XX XX pain. Reported diffuse pain throughout the XX XX after a work-related injury. States the pain is moderate and constant and reported an associated history of constant swelling. The pain improves with rest, ice, XX, and activity modifications. PE: XX XX Extremity: tenderness superior pole of the XX, exquisite XX XX line tenderness, decreased ROM secondary to pain, pain with increased flexion and full extension. Pain

with MCL stress superficial and XX XX, mild decrease in strength, XX strength 4+/5, pain and guarding with attempted medial McMurrays, Bounce painful. Assessment: XX XX pain, Complex XX of XX XX of XX XX as current injury, initial encounter, XX strain, XX, initial encounter. Plan: Ordered MRI XX, XX. PT and NSAIDs are only slight improvement of symptoms. Since XX still has such exquisite localized XX XX line tenderness and restricted ROM. Recommend MRI of the XX XX to evaluate for medial XX tear and if these images do not confirm tear, recommend proceeding with surgery. Continue working with restrictions as outlined on TWC form. Return after MRI.

XX: MR XX XX w/o Contrast dictated by XX. Impression: 1. No XX XX tear is identified. Mild XX degeneration within the body and posterior XX is present. 2. Mild XX of the XX. 3. No ligament tear or unhealed XX injury. 4. Grade 2 XX at the medial-most aspect of the medial compartment.

XX: Progress Note dictated by XX. CC: XX XX pain moderate and unchanged and has increased weakness and instability. PE: XX XX Extremity: tenderness superior pole of the XX, medial joint line tenderness, wearing wrap around XX XX, pain with extreme flexion and with full extension, mild decrease in strength, XX strength 4+/5. Assessment: XX XX pain, XX strain, XX. Plan: MRI did not reveal any medial XX tear, recommend continued conservative treatment at this time, regular regimen of XX XX, NSAIDs, and reinstituting XX therapy. XX will continue working with restrictions as outlined by TWC form for the XX month, then plan RTW full duty XX.

XX: Eval and Treat PT Order dictated by XX. XX XX sprain/strain, Continue Current Treatment Program XX weeks.

XX: XX Therapy Progress Note dictated by XX. CC: XX XX pain: constant pain XX XX, limited job functions, XX XX; pain/difficulty. LEFS prior 55%, current 76%. Assessment: re-evaluation findings are consistent with XX XX sprain/strain with grade II XX at medial most aspect of medial compartment. Expect slow but steady progress. Since returning to PT, claimant has completed XX of XX sessions with pain reduction from 3-8/10 to 3-6/10. XX ROM is WNL. Good response to use of XX to improve XX tracking. Strength is good except for XX which is limited due to pain and weakness. With tape in place, claimant denies pain. Claimant will benefit continued PT. Continue therapy XXx week for XX weeks.

XX: Progress Note dictated by XX. CC: XX XX pain with 50% improvement, reported moderate-severe pain, described as aching in nature and constant. Pain worsens with walking, standing, bending, lifting and walking up stairs and currently taking XX and XX for pain. PE: XX XX extremity: XX joint line tenderness, tender along XX XX and VMO, minimal offusion, XX XX. Pain with extreme flexion and with full extension, painful bounce, exquisitely painful medial and lateral XX. Assessment: XX XX pain, XX strain, XX. Plan: XX's XX joint line pain persists, reported XX still buckles/gives out on XX at times. Upon clinical exam, the claimant has exquisite pain with attempted XX and lateral XX testing. Painful bounce. Extensive PT tried. Recommend XX XX arthroscopy.

XX: Operative Report dictated by XX. Preoperative Diagnosis: internal derangement of the XX XX. Postoperative Diagnosis: internal derangement of the XX XX.

XX: Progress Note dictated by XX. CC: XX XX pain, s/p XX arthroscopy with XX resection of XX XX XX. Reported moderate post-operative pain and is recovering at home taking XX PRN for pain, which is not controlling XX pain. PE: XX XX extremity: diffuse tenderness and soft tissue swelling consistent with recent procedure XX appear benign with no drainage. Small post-op effusion. Limited ROM secondary to post-operative pain and effusion. Assessment: encounter for examination following surgery, XX XX pain. Plan: Instructed to continue wound care, XX massage. XX findings and procedures reviewed with the claimant at length and recommended to maintain daily post-op XX exercises and walking program as tolerated. Ice, elevation, and NSAIDs for discomfort. Supplement anti-inflammatory use with XX as needed. Progressively increase weight bearing status and ADLs as XX feels comfortable. Recheck in 1 week to ensure post-op effusion has subsided.

XX: Plan of Care dictated by XX. DX: pain in XX XX XX.XX. Assessment: LE XX both XX and XX involvement, impairments of the XX pain, decreased XX ROM, decreased XX strength, abnormal gait, balance deficits, poor posture of decreased WB on involved side. Mobility issues of walking, lifting or carrying, standing, sitting, stairs, transfers, squatting, kneeling, get up and down from the floor. XX. XX has increased XX pain, positive XX, decreased XX ROM,

decreased XX strength, decreased balance, all resulting in the following functional limitations: mobility issues of walking, lifting or carrying, standing, sitting, stairs, transfers, squatting, kneeling, get up and down from the floor. Self-care issues with XX and XX. Domestic life of difficulty with XX. Limitations: walking & moving around.

XX: Progress Note dictated by XX. CC: XX XX pain. Assessment: encounter for examination following surgery, XX XX pain, XX XX syndrome of XX side. Plan: Overall, the claimant is continuing to do well but states there is still discomfort with extreme flexion and extension. XX also states it feels as if XX XX is riding laterally. There is some XX with XX, but it is rather mild and returns to normal when the XX relaxes. After reviewing XX previous MRI and operative photos, XX XX and XX XX are normal appearing. XX has a point of tenderness over the ITB, recommend syndrome exercises. Ice and 2 XX BID pc for discomfort, ADLs as tolerated, continue working with restrictions outlined in TWC.

XX: Progress Note dictated by XX. CC: XX XX pain 4/10 moderate and constant, reported as aching, locking, swelling, loss of motion, loss of strength and deformity. Recommend surgery for recurrent XX XX instability. Submit for XX XX approval.

XX: Orders Note dictated by XX. DX: XX.XX XX recurrent XX instability; procedure code: XX XX diagnostic scope, MPFL and implants: XX MPFL SET, XX screw & XX tendon.

XX: UR performed by XX. Reason for denial: The records submitted for review would not support the requested procedures as reasonable or necessary. The claimant reported ongoing XX XX pain despite a previous XX resection completed in XX and post-operative XX therapy. The current physical exam findings noted a positive XX apprehension sign. However, there was no evidence of weakness, instability, or loss of range of motion on the most recent physical exam. Given these issues which do not meet guideline recommendations, this reviewer cannot recommend certification for the request. Recommend non-certification of the XX XX scope with XX implants, MPFL SET, XX screws, and XX tendon.

XX: Progress Note dictated by XX. CC: XX XX pain located at the medial aspect of the XX, started insidiously and no problems prior to this. Pain is moderate 4/10, aching, locking, swelling, loss of motion, loss of strength, and XX. The pain is present constantly, with certain activities and worse with running, stairs, bending, change in weather, and reported history of constant XX. The pain improves with rest, ice, pain meds, XX, and activity modifications. XX has tried PTC medications, relative rest, and activity modifications without significant improvement. Appealed denied surgery.

XX: UR performed by XX. Reason for denial: According tot eh documentation provided, the claimant had continued XX XX pain despite prior treatment with XX therapy, a XX XX, medication management, and prior surgery on XX. The claimant rated the current pain a 4/10 the claimant reported locking, swelling, loss of strength, and loss of motion to the XX XX. On physical examination, the claimant had XX of the XX muscle and XX instability with severe apprehension. A recommendation was made for a XX XX XX ligament reconstruction for this claimant. This request was previously denied given there was no evidence of weakness, instability, or loss of range of motion on the most recent examination and updated imaging was not provided documenting pathology to the medial XX ligament. Updated imaging for the XX XX was dated XX was provided for review. However, imaging of the XX XX documented the medial XX ligament, the requested surgical procedure is not appropriate for this claimant. Based on the above documentation, the requested XX XX scope with XX implants, MPFL SET, XX screws, and XX tendon is non-certified. The requested surgical procedure to the XX XX was not supported in the concurrent request for this claimant. As such, a postoperative XX XX is not appropriate for this claimant. Based on the above documentation, the requested T Scope Premier' XX XX is non-certified.

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

The request for XX XX medial XX ligament (XX) reconstruction is denied. This claimant injured XX XX XX on XX. The XX MRI demonstrated no evidence of XX tear. XX had grade 2 XX in the medial compartment. XX underwent diagnostic XX of the XX in XX, which included a XX resection. XX continues to have XX pain. The treating physician has recommended XX

reconstruction to address instability of the XX. XX reconstruction is commonly performed for XX instability, which has failed conservative treatment. However, it is unclear whether the XX injury or the XX resection has caused this claimant XX instability in the XX XX. Therefore, an examination of the XX joint of the XX XX is required, with comparison to the XX. A post-op MRI should also be performed to assess the XX directly and the position of the XX in the XX groove. In addition, there should be documentation of the patient's response to a XX with a XX cut-out and XX therapy to strengthen XX XX. The medial XX pain may be associated with the medial compartment XX or the XX resection. XX may benefit from a cortisone injection to the XX. Therefore, due to several outliers the request for XX XX Scope with XX Implants, XX SET, XX screws, and XX tendon T Scope Premier' XX XX is not medically necessary and the claimant is not a surgical candidate at the present time and the request remains non-certified or denied.

Per ODG:
XX

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**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **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)**