Becket Systems

An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

Total XX replacement of the XX XX.
XX - Repair, Revision, and/or Reconstruction Procedures on the XX (XX XX) and XX XX

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

Board Certified Orthopedic Surgeon

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

- ☑ Overturned (Disagree)
- ☐ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XX. XX is a XX-year-old XX who was injured on XX. XX was XX when XX XX and XX. XX was diagnosed with other XX of XX or XX of the XX, current (XX.XX).

XX. XX was seen by XX on XX for a follow-up of the XX XX. The XX pain was located all over the XX. It was diffuse and constant. It had been present for the previous XX months and was worsening. The pain was rated at XX/10. In addition to pain, there were complaints of swelling, catching, popping, locking, grinding, and clicking. There was also a complaint of XX. The examination of the XX XX revealed a moderately XX XX and painful range of motion. The XX was painful at XX degrees, and extension was painful at XX degrees. There was moderate XX, XX-XX XX XX tenderness, XX XX XX tenderness, XX tenderness, XX tenderness, a XX mass, and swelling. The diagnoses were XX pain and traumatic XX of the XX XX. The plan was to proceed with a total XX replacement of the XX XX.

An MRI of the XX XX dated XX showed XX XX tears, large XX XX defect of the XX XX XX, XX XX XX sprain, XX XX, and moderately large XX XX.

The treatment to date included medications (XX), rest, ice, elevation, a XX, and XX injections (partially alleviated symptoms) and XX intervention including a prior XX surgery.

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Per a utilization review decision letter dated XX, XX, denied the request for XX XX total XX replacement (length of stay not indicated) at XX. Rationale: "The Official Disability Guidelines (ODG) recommends total XX XX for the treatment of advanced XX when there has been a failure of conservative care, there is stiffness and marked daily pain despite conservative care, age is greater than XX, and there is evidence of advanced degenerative change on x-ray or previous XX, The provided documentation indicates progressively worsening XX XX pain with persistent swelling and mechanical symptoms despite extensive conservative treatment with rest, ice, nonsteroidal anti-inflammatory drugs (NSAIDs), a brace, XX and XX injections. The symptoms are causing an XX XX. There are physical examination findings of a significantly reduced range of motion, diffuse tenderness, and XX. The clinician notes that there have been previous radiographs and an ultrasound, but imaging results are not provided. While imaging studies likely reveal advanced XX, the medical necessity of the XX total XX replacement cannot be determined without documented imaging findings. Based on the lack of documented imaging findings, the XX total XX XX is not medically necessary. Recommend non-certification for the requested surgery - XX XX, total XX replacement (XX not indicated) XX."

Per a utilization review decision letter dated XX, an appeal had been received on XX. It was determined that the request for XX XX total XX replacement and XX-day inpatient stay at XX, still did not meet the medical necessity guidelines. The prior denial was upheld by XX. Rationale: "The request was previously denied as imaging studies were not provided. The clinical documentation submitted for review indicated this patient had pain in the XX XX with locking, grinding, clicking, popping, and swelling as well as a restricted range of motion and tenderness. Imaging showed pathology. However, there was no documentation noting the failure of conservative care to include physical therapy. There was also no information noting stiffness, nighttime joint pain nor the body mass index (BMI). Consequently, the request is not supported. As such, the requested surgery - XX XX, total XX replacement remains non-certified. The request was previously denied as the requested surgical procedure was not authorized. The clinical documentation submitted for review still did not provide the necessary information to warrant the surgical procedure. Consequently, the request is not supported. As such, the requested XX-day inpatient stay at XX is non-certified."

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

The initial denial was based on the lack of information regarding previous imaging. In reviewing the progress note from the treating provider, no discussion regarding imaging findings was provided. A subsequent MRI was obtained on XX (after the initial denial) demonstrating a large XX XX type injury to the weight-bearing XX portion of the XX XX XX and evidence of full-thickness XX XX surface loss along the XX XX of the XX. The subsequent review indicated that there is no documentation regarding failure of conservative care to include physical therapy; however, the previous progress note indicates a previous trial and failure of rest, ice, elevation, NSAIDs, XX, oral analgesics, and intra-articular XX. Conservative care had reportedly been provided for XX months. While a trial of physical therapy has not been attempted, it would not be anticipated that physical therapy would result in significant benefit given the XX XX defect of the XX XX XX. Given the additional information available including the MRI findings and documented failure of reasonable previous conservative XX, progression to XX XX would be considered reasonable for this individual given the full-thickness cartilage loss within the XX XX and the large XX XX on the XX XX XX as well as the age of the injured worker. Given the documentation available, the requested service(s) is considered medically necessary.

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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
- ☐ 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

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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.