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IRO REVIEWER REPORT

Date: 2/20/2019 8:45:00 AM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX arthroscopy with a XX, distal XX XX, extensive debridement, XX release, XX, loose body removal, XX XX repair and XX XX; and XX XX for purchase

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 was injured on XX. XX XX XX a XX-XX XX XX on the XX XX. XX was diagnosed with incomplete XX XX tear or rupture not specified as traumatic (XX.XX). XX. XX was seen by XX X, XX / XX XX, XX on XX for XX XX pain. The symptoms were gradually worsening. The pain was characterized as a dull aching. The aggravating factors included physical activity, any movement, overhead activity, and lifting. The symptoms were relieved with modification of activity. The symptoms were associated with painful range of motion, decreased range of motion, difficulty with pulling and lifting. On examination of the XX XX, the strength was 3/5 at the XX and 4/5 at the XX. There was popping with movement of the XX. Impingement and XX tests were positive. XX XX

adduction, XX load, XX test, XX test, XX tests were positive, superior XX XX XX (XX) prehension, XX, XX and XX tests were also positive. A magnetic resonance imaging (MRI) of the XX XX on XX documented a small, low-grade partial-thickness tear of the XX surface of the XX insertion; XX and moderate XX XX at the XX (XX) joint; and a type II XX. The XX XX complex and remaining XX were grossly intact. There was no full-thickness XX XX tear or XX XX of the XX XX muscle identified. The treatment to date included medications (XX and XX), XX therapy (XX), and a XX injection. The conservative treatment was not helpful. Per a utilization review decision letter dated XX, the request for XX XX arthroscopy with XX, distal XX XX, extensive debridement, XX release, XX, loose body removal, XX XX repair, and XX XX; and XX XX for purchase was denied by XX, XX. Rationale: "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 MRI of the XX XX showed an intact XX XX complex. Furthermore, clarification is needed if the prior authorized procedure for XX XX strain, XX XX repair, XX XX, XX (XX) joint XX, excision debridement XX, XX was performed. A more recent office visit is needed to determine the current patient status. As the primary request for surgery was not deemed medically necessary, this precludes the need for the ancillary request of a XX XX for purchase." Per a utilization review decision letter dated XX, the prior denial was upheld by XX. Rationale: "Per evidence-based guidelines, surgery is indicated after provision of conservative care in conditions with pertinent subjective complaints and objective findings corroborated by imaging. In this case, the patient did have a positive XX impingement test, XX impingement sign, XX crossover adduction test, XX load, XX test, XX test, XX test, superior XX XX XX tear (XX) prehension test, Speed's test, XX test, and XX test. However, the MRI of the XX XX still showed an intact XX XX complex. Moreover, the XX therapy (XX) note submitted had limited objective clinical findings to provide evidence of failure from conservative treatment. 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 MRI of the XX XX still showed an intact XX XX complex. Moreover, the XX therapy (XX) note submitted had limited objective clinical findings to provide evidence of failure from conservative treatment."

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

The claimant's MRI studies for the XX XX noted a mild partial thickness XX of the XX XX with moderate XX XX. There was no XX pathology. The claimant still reported XX XX pain despite XX therapy and injections. However, the most recent physical exam findings in XX of XX were limited. There was no significant loss of range of motion reported in the XX XX. Given the limited imaging findings, there were no clear indications to proceed with the extensive number of procedures requested.

Therefore, it is this reviewer's opinion that medical necessity for the requests 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