P-IRO Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 3/12/2019 2:43:26 PM CST

P-IRO Inc.

An Independent Review Organization
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IRO REVIEWER REPORT

Date: 3/12/2019 2:43:26 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX arthroscopic assisted superior XX reconstruction

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 initially injured XX XX on XX while XX XX XX, XX-XX XX XX. XX worked as a XX at XX XX XX. On XX, XX, XX evaluated XX. XX for a postoperative checkup. XX. XX was status post XX XX XX repair (XX) on XX. The pain was constant and rated as 6-7/10. XX would like to discuss other options since XX XX had denied XX second surgery. XX XX examination revealed no deformity, XX, soft tissue swelling, joint effusion, XX or XX. Surgical incisions were well healed. On palpation, there was mild tenderness noted at the XX corner of the XX and XX aspect of the XX. Range of motion of the XX XX was forward flexion of 70 degrees, abduction of XX degrees, external rotation of 20 degrees, and internal rotation to XX. The strength was 4/5 in abduction, external rotation, flexion, and XX. XX had a positive drop XX and empty can tests. XX. XX administered injection XX-XX in the XX

XX intra-articular space. XX. XX opined that XX. XX had a re-tear of XX XX and XX would benefit from superior XX reconstruction, which unfortunately was denied by XX XX. XX. XX would like to have pain control and in the interim they would try to appeal. An MRI of the XX XX obtained on XX revealed a full-thickness XX in the XX XX XX, involving the XX XX greater than XX tendon. There was moderate XX and mild XX volume loss and fatty change. Moderate proximal XX XX was noted. There was mild / early XX XX. XX XX was slightly XX positioned in the XX. XX XX was XX evaluated due to motion artifact. Small XX XX were not excluded. Additionally, there was moderate XX (XX) XX / XX, small amount of joint fluid and mild XX-XX XX fluid / XX. An MRI of the XX XX obtained on XX revealed prior XX XX repair with XX XX and XX-XX XX XX / XX. There was a large near-complete recurrent XX refractile XX of XX grade 2. The findings included a high-grade XX tendon XX with attenuated caliber, XX and a possible full-thickness component leading margin insertion, XX grade 3 with muscle volume loss, mild-to-moderate XX XX with intrasubstance partial XX, XX grade 0. There was relatively high-riding XX XX and mild XX XX. There was moderate joint effusion with XX and XX-XX extension. There was proximal long XX XX XX without a refractile XX or dislocation. Posterosuperior XX XX degeneration was noted. There was prominent XX XX XX complex with XX interval edema. Nonspecific XX, including mild adhesive XX were considered. The treatment to date consisted of medications (XX, XX-XX, XX), preoperative XX therapy (completed), surgery (XX XX arthroscopic-assisted XX XX repair of the XX and XX tendons and XX XX arthroscopic assisted debridement of the XX XX and XX tendon XX). Per a utilization review determination letter dated XX, the request for XX XX arthroscopic assisted superior XX reconstruction was non-certified. Rationale: “Claimant has not undergone any postoperative PT / conservative care for surgery that was performed on XX. MRI does not reveal an acute re-tear as noted in the results above. Recommend attempt at conservative care prior to XX XX arthroscopic assisted superior XX reconstruction.” Per a utilization review determination letter dated XX, the request for XX XX arthroscopic assisted superior XX reconstruction was non-certified. 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. This request does not meet the ODG-TWCC guidelines XX / Surgery for RCR. MRI that was conducted does not note there was an acute re-tear. There has been no documentation that the IW has had any post-operative PT and / or conservative care. Furthermore, after speaking with XX, XX stated that the patient has a re-tear of the XX XX on MRI. The patient does not fully meet the requirements for the requested procedure. The patient’s symptoms, physical findings, and MRI-enhanced imaging do not support the need for the requested procedure. The requested procedure is shown to have inferior results than primary repair. Therefore, all of the above requests are not medically necessary.”

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

The claimant’s MRI studies of the XX XX through XX demonstrated an irreparable XX XX tear with associated XX XX and XX degeneration. The claimant has a substantial loss of range of motion and weakness of the XX XX that is consistent with the MRI studies. The extent of the MRI pathology would not be resolved with non-operative measures. The extent of the pathology on MRI also rules out any reasonable attempt at a XX XX repair. The proposed superior XX reconstruction is a reasonable option in this case. Given the documentation available, the requested service(s) is considered medically necessary.

Therefore, it is this reviewer’s opinion that medical necessity for the request is established and the prior denials are overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

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☐ 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

Superior capsule reconstruction (XX procedure)