Clear Resolutions Inc.

An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

XX XX arthroscopy with XX of XX and debridement,
postoperative XX XX
XX: Arthroscopy of XX, surgical with extensive debridement
XX: Arthroscopy of XX, surgical with disintegration of lesions
XX: XX XX XX XX orthosis, abduction positioning, XX design, prefabricated, includes fitting and adjustment

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 XX is a XX-year-old XX who was injured on XX. XX had to XX XX XX XX, and XX XX got XX XX in an XX XX, XX XX XX XX. XX was diagnosed with superior XX XX lesion of the XX XX, XX XX of the XX XX, xX of the XX XX, and XX XX of the XX XX.

On XX, XX. XX underwent a XX XX arthroscopic XX XX by XX, XX for a postoperative diagnosis of XX XX superior XX anterior-posterior (XX) tear with unstable XX insertion; and a very XX / mild XX undersurface tear.

On XX, XX. XX was seen by XX. XX for complaints of XX XX pain, described as sharp, aching, burning, dull, numb, and tingling sensation to all XX, radiating down the XX to the XX. The pain worsened with increased activity and with overhead activity and improved with rest. XX reported that XX symptoms were unchanged, and XX continued to have pain and catching symptoms in XX XX at the time, and XX XX surgery had been denied by XX XX. XX had been medically XX from XX job and did not have a XX available. On examination of the XX XX, there were typical postoperative findings noted, including positive Neer's, Hawkins', Speed's, and O'Brien's tests. There was moderate tenderness in the entire XX. The range of motion was moderately decreased. The strength and tone were moderately decreased. The diagnoses were superior XX XX lesion of XX XX, subsequent encounter; XX XX of XX XX; XX of XX XX; and adhesive XX of XX XX. XX. XX had XX XX and was dealing with some XX at the time. XX. XX believed it was some scar tissue that was causing local impingement and XX. Given that XX. XX had failed a long course of conservative treatment with therapy and activity modification and still causing significant disability, XX. XX thought XX was a good candidate for surgical intervention. This would include arthroscopic debridement with XX of XX. XX, therefore, wanted to resubmit the request to see if approval for surgery could be obtained. At the time, XX. XX did not have a XX available, so it was a XX point whether or not XX could get back on light duty.

On XX, XX. XX in XX follow-up visit noted that XX. XX continued to have significant problems with regard to XX XX XX. XX had tightness that limited XX activities because of loss of motion. XX had continued XX home therapy exercises but also felt there was a significant weakness in the XX. XX was just over a XX from XX surgery and had been XX from XX XX because of XX inability to return to full work status. Examination of the XX XX showed rotator cuff weakness with range of motion of forward flexion 60 degrees, abduction 45 degrees and then scapulothoracic motion took over up to 80 degrees, internal rotation was just past the trochanter, and external rotation 20 degrees. The strength and tone were significantly decreased as well. The diagnoses included adhesive XX of the XX XX, pain in the XX XX (history of XX XX), and traumatic arthropathy of the XX XX. XX. XX had a lengthy discussion about XX. XX's XX XX problems. XX had healed XX XX XX, and XX last MRI showed no new tears, but XX was, at the time, dealing with significant and continued adhesive XX. XX. XX was hopeful that they could get XX through this nonoperatively, but XX. XX was, at the time, just over the year mark and continued to have significant loss of motion and weakness. Because of this, XX. XX was concerned that XX was not going to see improvements without some surgical intervention to include arthroscopic XX of XX with indicated procedures. XX felt XX. XX was a good candidate for this, and believed it would help XX get back to full function and back to full-duty status at work. XX. XX noted the XX XX was directly related to XX. XX's work injury as such, and recommended proceeding with surgical intervention.

X-rays of the XX XX dated XX showed normal XX XX with no fracture, XX, or dislocation seen.

MRI of the XX XX dated XX identified intact-appearing proximal XX XX with mild granulation tissue adjacent to the anchor / interference screw; minimal XX (XX) joint XX; postsurgical changes superior XX; and no high-grade partial or full-thickness XX XX XX.

Treatment to date included XX therapy, steroid injections, and surgical procedure without much relief.

Per a utilization review dated XX, XX, XX denied the request for XX XX arthroscopy with XX of XX and debridement, and postoperative XX XX as not medically necessary. Rationale: "Based on the medical records submitted for review, the claimant has continued pain in the XX XX. According to the guidelines, surgery for XX XX is recommended after failure of a minimum of XX months of conservative treatment to include XX therapy, corticosteroid injection, and anti-inflammatories. It was noted that the claimant did complete a full course of postoperative XX therapy, but there is no documentation to support a corticosteroid injection. There must be objective clinical findings of decreased passive XX flexion and abduction less than 130 degrees, which are not documented on most recent office evaluations. The guidelines also state the patient must be capable and willing to strictly follow a postoperative rehabilitation protocol, which Is not documented. The guidelines recommend XX immobilization following surgery, but as the XX surgery is not medically supported, this negates a need for postoperative immobilization. The request for XX XX arthroscopy with XX or adhesions and debridement and a postoperative XX XX is not certified."

Per an adverse determination letter dated XX, orthopedic surgeon XX, XX, XX non-authorized reconsideration for XX XX arthroscopy with XX of XX and debridement, and postoperative XX XX as not medically necessary. Rationale: "The patient sustained a XX XX injury which occurred on XX and subsequently the patient underwent an arthroscopic XX XX on XX. The patient has been medically separated from the job and continues to report XX XX pain, stiffness, catching with motion and inability to perform overhead activities after XX XX of post-surgical treatment and conservative care. Medical records report 100 degrees of active forward flexion and 95 degrees of active abduction. An MRI shows mild granulation tissue around the XX XX anchor and mild thickening of the capsule in the XX XX without signs of remote adhesive XX. ODG indicates that capsular release is more successful for primary adhesive XX than for post-surgical stiffness. Criteria for manipulation under anesthesia or capsular release require 6 months of conservative care including XX therapy, corticosteroid injection, and NSAIDS. There should also be subjective clinical findings and disabling pain and stiffness, and objective clinical findings of passive XX flexion and/or abduction less than 130 degrees. Post-operative XX immobilization in a XX is recommended for XX-XX weeks after XX surgery. Available records document home PT and supervised therapy postoperatively, however, a steroid injection or additional measures to improve motion not documented. Available post-operative MRI report does not indicate severe findings or evidence of adhesive XX to support further surgical care. No documentation of restricted passive XX motion is available to document the diagnosis of adhesive XX. Based on the available clinical records, medical necessity has not been met to support the current request, therefore, is denied."

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Notice of Independent Review Decision

Case Number: XX Date of Notice: 03/04/19

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

The claimant has been followed for a XX post-operative outcome for the XX XX with reported loss of range of motion. The provided records did not include any XX therapy progress reports monitoring the claimant's response to therapy or demonstrating that the claimant had reached a reasonable plateau with therapy to support proceeding with further surgery. Additionally, the most recent evaluation of the XX should did not include a comparison between the reported range of motion and any passive measurements to demonstrate adhesive XX. Therefore, 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-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

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Notice of Independent Review Decision

Case Number: XX Date of Notice: 03/04/19

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

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.

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