IRO Express Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 3/18/2019 11:41:45 AM CST

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IRO REVIEWER REPORT

Date: 3/18/2019 11:41:45 AM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX diagnostic arthroscopy, XX XX repair, XX decompression, XX XX XX, XX XX and indicated procedures.

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

XX XX diagnostic arthroscopy is not medically necessary.
XX XX repair, XX decompression, XX XX excision, XX XX and indicated procedures are medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: XX. XX XX is a XX-year-old XX-XX dominant XX who sustained an injury on XX while XX a XX off the XX. XX was diagnosed with pain in the XX XX (XX.XX). The additional diagnoses included XX pain, impingement, massive (full) XX XX tear, XX strain, posttraumatic XX (XX) XX, XX joint sprain, XX XX, XX / XX numbness, XX XX syndrome (XX), XX pain, and XX XX. XX. XX was seen by XX on XX for XX XX pain. XX experienced XX XX popping, pain, and weakness secondary to XX injury. XX had burning pain down the XX and numbness / tingling in the XX. The pain was described as constant / sharp / dull / achy / burning, rated at 8/10 at rest and 8/10 at worst. XX reported numbness /

tingling, popping / clicking, and weakness. The symptoms were worse with activity / bearing weight, and improved with nothing / rest. XX felt that the affected area was 50% normal. Examination of the XX XX showed tenderness on palpation over the XX joint, XX groove. The active range of motion was painful and showed 60 degrees of forward flexion, 20 degrees of external rotation, and internal rotation to XX. The passive range of motion revealed 110 degrees of forward flexion, 40 degrees of external rotation, and internal rotation to XX. There was pain with end ranges of motion. The motor strength was 4/5 with external rotation (ER) and "3/5SS" with internal rotation (IR). Impingement sign, painful arc, drop XX, Speed test, and XX tests were positive. XX recommended surgical intervention as the XX was getting weaker and more painful. The delay in surgical treatment would cause supraspinatus fatty muscle atrophy. The initial CT on XX showed mild fatty atrophy which was not a contraindication for XX XX XX surgery. XX. XX had worsening pain and weakness due to delay in surgical treatment. XX had undergone XX sessions of XX therapy and it made the XX more painful. A CT arthrogram report of the XX XX dated XX documented a full-thickness tear of the XX tendon with XX cm of medial retraction and fatty atrophy of the XX XX XX, chronic degeneration of the XX XX, a normal XX tendon, XX of the XX joint with joint space narrowing, XX, evidence of prior XX, and XX XX resection. A CT scan of the XX XX dated XX showed increased XX distance could be seen with grade XX separation versus previous XX. There was suspicion for possible XX XX tear and mild fatty atrophy of the XX. Additional moderate degenerative changes of the XX joint were noted. The treatment to date included medications (XX, XX, and XX), chiropractic therapy, and XX sessions of XX therapy without improvement, AC joint and XX injection with 50-75% improvement, XX XX open XX XX repair and XX XX resection in XX. He had failed all conservative management. Per a utilization review decision letter dated XX, the request for XX XX diagnostic arthroscopy, XX XX repair, XX decompression, XX XX excision, XX XX was denied by XX. Rationale: "The request is for XX XX diagnostic arthroscopy, XX XX repair, XX decompression, XX XX excision, XX XX, and indicated procedures. The Official Disability Guidelines (ODG) supports diagnostic arthroscopy of the XX when imaging has been inconclusive and pain and functional limitation persist despite conservative care. The documentation provided indicates that the injured worker has ongoing complaints of XX XX pain that has failed to improve with injection, nonsteroidal anti-inflammatory drugs (NSAIDs), and XX therapy (PT). A computed tomography (CT) XX documented XX XX, degenerative XX tear, and a full thickness tear of the XX tendon with retraction and fatty atrophy. The provider has indicated a diagnosis of XX XX pain, impingement, XX XX tear, strain, posttraumatic XX XX, XX joint sprain, XX XX, and XX XX. The provider has recommended a diagnostic arthroscopy in addition to a XX XX repair, XX decompression, XX XX excision, and XX XX. Based on the documentation provided, the ODG would not support the requested diagnostic arthroscopy, as there is no indication that imaging is inconclusive. Therefore, the request is recommended for non-certification." Per an adverse determination letter dated XX, the prior denial was upheld by XX. Rationale: "The request is for XX XX diagnostic arthroscopy, XX XX repair, XX decompression, XX XX excision, XX XX, and indicated procedures. Diagnostic arthroscopy was previously denied because there was no indication that imaging was inconclusive. XX XX repair was denied because it was unclear the degree of atrophy of the XX muscle, and the Official Disability Guideline (ODG) does not support XX XX repair when there is significant fatty infiltration on imaging as there is increased risk of failure of a XX XX repair when atrophy is present. XX decompression was denied because the claimant had not met earlier surgical criteria for an associated XX diagnosis, there had not been a failure of conservative care for at least XX year, and there was no documentation of mechanical impingement on imaging. XX XX was denied because there was no evidence of XX pathology on imaging. XX XX resection was denied because there was no indication in current imaging that there was post-traumatic XX of the XX joint (XX) joint. The request remains not medically necessary. The Official Disability Guidelines (ODG) support diagnostic arthroscopy of the XX when imaging has been inconclusive, and pain and functional limitation persist despite conservative care. The provider indicates that the claimant has ongoing complaints of XX XX pain that has failed to improve with injection, non-steroidal anti-inflammatory drugs (NSAIDS), and XX therapy. A computed tomography XX documented XX XX, degenerative XX tear, and a full thickness tear of the XX tendon with retraction and fatty atrophy. Based on the documentation provided, the requested diagnostic arthroscopy is not indicated as imaging is not inconclusive. Therefore, the request is recommended for non-certification. The claimant complains of popping, pain, and weakness. A physical examination documents tenderness over the XX joint and XX

groove, decreased active and passive range of motion, 4/5 strength, positive impingement, a painful arc, and a positive drop XX. A CT arthrogram of the XX XX extremity documented XX of the XX joint and a full thickness tear of the XX tendon with retraction and fatty atrophy of the muscle XX. The degree of atrophy was not documented. Based on the documentation provided, the degree of atrophy of the XX muscle is unclear. The guideline does not support XX XX repair when there is significant fatty infiltration on imaging. Therefore, the request is not medically necessary. The guideline supports surgical intervention in the form of XX XX for advanced XX XX. When a history, physical examination, and imaging indicate significant XX tendon pathology. Based on the documentation provided, there is no evidence of XX pathology on imaging. Therefore, the request is recommended for non-certification."

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

The provided records demonstrated an old XX XX tear at the XX tendon with retraction by XX and muscle atrophy. This imaging finding does correlate with recent physical exam findings demonstrating impingement of the XX XX. Mild weakness was noted and there was a substantial loss of active range of motion. The claimant had tried XX therapy for XX sessions with severe pain. Given the extent of pathology at the XX XX, it is unlikely that the claimant would improve with further non-operative measures. There is a reasonable opportunity to improve range of motion of the XX XX with surgical repair of the XX XX. The extent of the pathology would support proceeding with XX decompression, XX XX XX, and XX XX. There are clear imaging findings in this case and a diagnostic procedure would not be needed.

Therefore, it is this reviewer's opinion that the surgical requests to include XX XX repair, XX decompression, XX XX excision, XX XX are medically necessary only and the prior denials for these procedures are overturned. The diagnostic arthroscopy portion of the procedures in question are not medically necessary and therefore upheld.

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

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES