Independent Resolutions Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 3/6/2019 9:57:52 AM CST

Independent Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (682) 238-4977
Fax: (888) 299-0415
Email: carol@independentresolutions.com

IRO REVIEWER REPORT

Date: 3/6/2019 9:57:52 AM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX XX AL decompression

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. While working as a XX XX for a XX XX, XX was XX to the XX XX from XX. As XX was XX XX the XX-XX XX from the XX XX XX XX, XX XX got XX in the XX-XX XX to the XX. XX was XX XX, and XX XX and XX as XX was XX XX into the XX. XX reportedly XX XX XX. The diagnosis was sprain of XX ligament of the XX XX. XX. XX was evaluated by XX, XX on XX for a follow-up of XX XX XX. XX was having significant XX XX instability and was XX with XX. On examination, XX had good range of motion of the XX, very strong positive drawer's sign on the XX and the XX. XX had significant instability in XX XX. XX had a somewhat wobbly gait and needed lateral support. XX had XX XX to XX. The diagnoses were sprain of the XX ligament of the XX and XX XX, initial encounter. It was noted that XX. XX had a functional capacity evaluation (FCE), and they almost disabled XX at 80%. XX could not perform XX previous job, could not walk around any length of time. The plan was to consider XX repairs one

at a time. On XX, it was noted that XX. XX had XX significant XX instability. XX did have a positive anterior drawer sign that was very significant on both sides. XX. XX stated XX. XX was definitely in need of XX XX repair to give XX stability in the XX. A prescription for XX was given, and XX. XX was continued on XX off-work status. On XX, XX. XX informed XX. XX that they had to take stress x-rays of the XX, which he agreed was correct as per the Official Disability Guidelines (ODG); however, he indicated that there were a lot of false negatives with this because of XX XX, which this maneuver caused. A stress x-ray was obtained of the XX, and there was at least 40 degrees of XX on the XX XX and about 25 degrees on the XX XX. XX. XX believed XX. XX definitely needed a reconstruction of the XX because the instability was so XX, and he was not fully convinced that a XX would be sufficient to get the stability back. An MRI of the XX XX was obtained on XX. The study identified a ruptured anterior XX ligament (XX); possible XX of the XX ligament-XX attachment versus moderate-to-severe XX sprain; mild diffuse XX XX; XX XX central XX origin mild acute XX with possible superimposed tiny partial-thickness tear; mild XX XX XX XX; and small XX joint effusion. Treatment to date included immobilization, XX, XX therapy, injection and oral medications (XX, XX, and XX). Per a utilization review dated XX, by XX, XX, the request for XX XX XX XX ligament XX was non-certified. The primary reason for the determination was: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Guidelines recommend surgery for positive clinical findings corroborated with imaging studies and having tried conservative treatments. The MRI of the XX XX dated XX revealed ruptured anterior XX ligament (XX). There was XX ligament XX attachment may be torn versus moderate / severe distal sprain. There was mild diffuse XX XX. There was a XX XX XX XX origin mild XX XX with possible superimposed tiny partial-thickness XX. There was a mild XX XX XX XX and a small XX joint effusion. In this case, the patient complained of significant problems still with both XX. The provider recommended XX XX XX AL decompression; however, there was still limited significant objective findings and functional limitations that would fully support the need for the requested surgery. Also, the provision of conservative treatments that was tried and had failed was still not established in the medicals provided as there were no XX therapy notes submitted before considering surgery." A utilization review was completed on XX by XX, XX, regarding the appeal for XX XX XX AL decompression (XX, XX, XX). The request was non-certified. Primary reason for determination: "There should be a positive stress x-ray performed by a physician identifying motion at the XX or XX joint. At least 15-degree lateral opening at the XX joint or demonstrable XX movement and negative to minimal joint changes on x-ray to fully warrant the surgery request. Furthermore, clear evidence of conservative treatments was not fully established. Detailed objective evidence of a recent, reasonable and/or comprehensive non-operative treatment trial and failure should be considered prior to considering procedural levels of care."

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

The clinical findings demonstrated a significant XX XX sprain injury with a XX of the anterior XX ligament. There were probable XX of the XX ligament. While there are objective findings to support surgical consideration, the provided records did not include any documentation regarding prior non-operative care to include formal XX therapy. Without understanding the claimant's progress through XX therapy prior considering surgical intervention, it is this reviewer's opinion that prior denials are upheld.

Given the documentation available, the requested service(s) is considered not medically necessary and the decision is upheld.

Independent Resolutions Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 3/6/2019 9:57:52 AM CST

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

Surgery for XX sprains Recommended as indicated below for XX XX sprains.