Core 400 LLC

An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

XX XX XX with extensive debridement, partial XX, and possible decompression of the XX space, outpatient
XX XX of XX, surgical, with extensive debridement
XX XX, XX, surgical; decompression of XX space with partial XX, with XX ligament (i.e., XX) release, when performed (List separately in addition to code for primary procedure)

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Orthopedist

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 was XX with a XX-XX XX XX to XX XX a XX, when XX felt like XX had XX a XX. The diagnosis was sprain of unspecified parts of the XX XX XX, subsequent encounter (XX.XX).

XX. XX was evaluated by XX, XX on XX for a complaint of XX pain. XX appeared for a follow-up of the XX XX sprain. XX reported that XX XX was worse since the prior visit. XX reported that XX surgery had been denied and XX had been scheduled to have maximum medical improvement evaluation. XX also reported that XX continued to go work under “light duty,” but they were not respecting the restrictions. XX located the pain in the posterior aspect of the XX and all over the XX XX. The pain was 5/10. XX stated XX was unable to get dressed on XX own and needed assistance. On examination of the XX XX, there was mild-to-moderate swelling, positive XX with range of motion, decreased flexion, notable tenderness, and positive XX XX test. XX. XX was educated on XX strengthening exercises and was instructed to avoid activities that caused or worsened the pain. XX was not to resume XX normal level of activity until XX had been rechecked. XX and XX were started. XX. XX noted that XX. XX had undergone XX therapy, an injection, and rest without any relief. XX had undergone conservative management for four to XX months without relief.

An MRI of the XX XX dated XX showed moderate degenerative changes of the XX (XX) joint surrounded by moderate XX XX XX, a small XX joint effusion, and a small amount of fluid in the XX / XX XX, which could be producing symptoms of XX. X-rays of the XX XX dated XX showed no fractures.

The treatment to date included medications (XX, XX, XX, and XX), activity modification, ice, rest, XX injection, and XX therapy. None of these were helpful.

Per a utilization review decision letter dated XX, the request for the XX XX XX with extensive debridement, partial XX, and possible decompression of the XX space, outpatient, between XX and XX was denied as not medically necessary by XX, XX. Rationale: "XX."

Per an undated letter by XX for XX, XX. XX was seen for the first time by XX on XX for XX XX strain, but was notable for XX XX XX and XX per the MRI that XX brought; and being this far out from the initial date of injury, the state of the XX was chronic. It was noted that since XX. XX had exhausted the initial conservative treatment options and was unchanged in progress, the next option was for aggressive treatment. It was felt that XX. XX would benefit from XX XX XX with extensive debridement which would include the partial XX, and possible decompression of the XX space. Per the Official Disability Guidelines (ODG), under aggressive treatment, it was stated that decompression / XX alone should be performed after at least XX weeks of conservative management.

Per a utilization review decision letter dated XX, the reconsideration request for XX XX XX with extensive debridement, partial XX, and possible decompression of the XX space as outpatient was noncertified. The prior denial was upheld by XX with the following rationale: "It is not clear what the author of the additional medical records provides from a clinical perspective. It is understood that XX months of conservative care has been completed, however, this is less than the XX months required as outlined in the Official Disability Guidelines. Furthermore, there is no current clinical assessment demonstrating the finding of this XX pathology. As such, the clinical data presented on the objective need for a multifaceted XX XX intervention. After speaking with XX, it was stated that is has been XX months since DOI. The patient has been treated with injections, a couple of rounds of XX therapy, XX meds, and modification of activities. The MRI is consistent with XX and impingement. The patient does not fully meet the criteria per ODG guidelines. The patient was found to not have XX XX tear on MRI. There are degenerative changes about the XX joint. The previous injections were not documented to be specific to the XX joint. Therefore, the request is not supported."

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

The ODG supports the use of operative intervention as an option for management of XX impingement after at least XX months of conservative treatment. The documentation available indicates at least XX months of conservative treatment has been implemented with XX therapy, XX medications, and corticosteroid injections. The provider has requested debridement and XX decompression. There is no indication that XX joint resection or XX XX repair have been requested. The objective examination findings are consistent with XX impingement as are the MRI findings. While the injured worker has not completed XX months of conservative treatment, the guidelines would not support further conservative interventions and given the duration of treatment and documented failure of conservative modalities, progression to surgical intervention would be considered medically necessary and deviation from the guidelines is warranted for the requested operative intervention. Given the documentation available, the requested service(s) is considered medically necessary.

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

Case Number: ***XX*** Date of Notice: 02/21/19

- [x] 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

You have the right 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.