IMedReviews
14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

DATE OF REVIEW: 4/29/2019

IRO CASE # XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

"XX XX Arthroscopic XX XX, possible XX repair, as outpatient" for the patient.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D. Board Certified in Orthopedic Surgery and Sports Medicine.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX-year-old XX with a history of a work-related injury to XX XX XX from a XX XX XX on XX. As of XX last progress note dated XX XX continued to have anterior and posterior XX XX pain that was worse with movements and lifting. XX has been treated with NSAIDs, pain medications, work restrictions, and XX sessions of XX which helped XX ROM but not XX pain. At the time of the visit, XX had 0/10 pain. XX physical exam was positive for some mild decrease in ROM. XX had a XX empty can test as well as positive Speeds test and positive apprehension tests. XX had negative impingement tests and a negative XX's test. XX had an x-ray that showed post-operative changes from prior XX repair but no other abnormalities. XX has had a non-contrast MRI of the XX XX and an MR arthrogram of the XX XX that suggest a XX tear with some involvement of the XX XX. The request is for a XX XX arthroscopy with XX XX and possible XX repair.

IMedReviews
14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

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

Per ODG references the requested "XX XX Arthroscopic XX XX, poss XX repair, as outpatient" is not medically necessary.
This request was previously denied around XX months ago due lack of adequate length of time of conservative treatment. It has now been about XX months from XX injury which would constitute an adequate time period of conservative treatment but there is no documentation since the last denial in XX to update the patient's clinical status. There is also no new documentation of continued/further conservative treatment with further XX or injection and no documentation of any response or lack of response to this. If documentation of this continued conservative care with lack of improvement could be provided, then the surgery could be approved but without documentation of this I agree with the prior recommendation that the surgery not be certified until documentation of failure of XX months of continuous conservative care can be shown.

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 KNOWLEDGE BASE
- ☐ AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & 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