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Date notice sent to all parties: 05/06/19

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX XX arthroscopy with XX

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

Board Certified in Orthopedic Surgery

REVIEW OUTCOME:

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

X Upheld (Agree)

☐ Overturned (Disagree)

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

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

XX XX arthroscopy with XX – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

A XX XX arthroscopy with XX was authorized on XX. XX. XX examined the patient on XX. XX had undergone surgery, but then went to XX. XX had popping sensation and a burning sensation in the XX XX for XX years. XX rated XX pain at 10/10. XX had a

neutral alignment and x-rays that day revealed mild XX. XX. XX saw the patient on XX and requested a new XX XX, as XX was worn out. XX XX XX screen was positive for XX and XX as expected, but was also positive for XX and XX for which XX had no excuses. XX noted XX took XX XX's XX for a XX, but could not explain the XX. XX walked without a limp and range of motion was 0-90 degrees. XX ligaments appeared intact. There was no effusion. XX was given a hinged XX XX and because XX XX the pain management agreement, XX. XX noted XX would no longer XX XX XX. XX stated XX would find a different physician. A XX XX MRI on XX revealed progress of XX tear involving the posterior XX and body of the medial XX. There was interval resolution/healing of previously seen marrow XX and XX lesion involving the medial XX XX. There was stable XX XX with mild marrow XX and XX change at the XX suggesting some mobility. XX. XX reexamined the patient on XX. XX was frustrated because XX endorsed significant pain and had been released by XX. XX for failing XX latest XX screen. After reviewing the MRI, XX. XX noted XX would not prescribe XX, but would order a XX injection. XX. XX noted XX expected the patient to transfer care due to XX XX over pain medication. On XX, the patient returned to XX. XX in pain claimed to be 10/10. XX sat comfortably, but was very XX and XX. XX moved about the room and got on the exam table comfortably. XX ligaments appeared intact and XX had good range of motion. XX would follow-up on XX for a XX injection and a XX XX screen was collected. If negative, they would discuss pain medication. On XX, a long discussion was had regarding XX age and condition that a XX was far more likely than a XX repair because XX ability to heal postoperatively is limited. A steroid injection was suggested and was done at the time. On XX, the patient still had significant XX pain and wanted to extend XX XX to every XX hours instead of XX. XX also had a XX XX XX and mild XX XX XX pain. XX also had XX XX from a new job, all of which were unrelated to this injury. XX had discomfort XX and stated XX had not been able to pass XX since the night before in regard to undergoing a XX screen. XX had taken XX last XX the night before. It was felt the patient needed arthroscopic surgery and XX was refilled. On XX, the patient noted XX got XX day of relief from the XX shot and XX rated XX pain at 10/10. XX was taking XX XX per day and wanted to proceed with surgery. XX had no effusion in the XX XX and range of motion was normal. XX, XX, posterior drawer, and XX and varus stress testing were negative. The impression was a medial XX tear and chronic XX XX pain. A XX XX arthroscopy with XX of the XX XX was recommended at that time. A preauthorization request was submitted on XX. On XX, a non-authorization was submitted for the requested XX XX surgery. On XX, another non-authorization was submitted for the requested XX XX surgery.

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

The findings on the XX XX MRI scan that was obtained XX showed a XX tear. The medial XX has a XX tear, an increased signal within the anterior horn, which reflects degenerative signal. This is also seen in the presence of degenerative changes within the lateral XX XX. Plain films x-rays showed decreased XX XX line space. The Official Disability Guidelines (ODG) has different requirements for a XX for a XX XX tear than for an acute XX tear because the peer-reviewed medical literature has shown that XX in

the presence of a XX tear is not beneficial and will lead to increased XX care. For a degenerative XX, the ODG states that the XX tear requires locking, which is not present in the history or on the examination. While there is limited flexion and subjective pain complaints, there is no objective evidence of locking. In addition, there is no positive XX sign or other objective evidence of XX pathology. The patient has had difficulties with XX usage and reports pain scores that are out of proportion to the physical findings. In the absence of significant objective findings such as locking, the ODG would not endorse the need for XX. Therefore, in my medical opinion, the requested XX XX arthroscopy with XX is not medically necessary, appropriate, or in accordance with ODG and the previous adverse determinations should be upheld at this time.

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**

☐ **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**

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X 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 (PROVIDE A DESCRIPTION)**