IRO Express Inc.

Notice of Independent Review Decision

Case Number: Date of Notice: 5/21/2019 1:44:14 PM CST

IRO Express Inc.

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INFORMATION PROVIDED TO THE IRO FOR REVIEW: • Clinical Records –XX/XX/XXXX/XX/XX, XX/XX/XX, and XX/XX/XX
• Notification of Adverse Determination –XX/XX/XX and XX/XX/XX
• Physical Therapy Notes –XX/XX/XX and XX/XX/XX
• Diagnostic Data Reports –XX/XX/XX, XX/XX/XX and XX/XX/XX

PATIENT CLINICAL HISTORY [SUMMARY]: XX. XX XX is a XX-year-old XX who was injured on XX. XX twisted XX XX XX while XX. XX was diagnosed with pain in the XX XX and XX XX XX instability. XX. XX was evaluated by XX XX, MD on XX for XX XX pain. XX complained of XX pain in XX XX. XX described the pain as sore, XX, and XX. The pain was rated at 6/10. XX experienced instability, XX / XX, XX pain, and pain with XX / XX. The location of the pain was described as XX, XX, and XX. The symptoms were worse with XX, XX, XX, XX, XX, XX XX, XX, XX, and XX in XX. The plan was to proceed with XX intervention.

On XX/XX/XX, XX. XX was seen by XX XX, MD for continued XX XX pain and a sense of laxity at times. XX stated that the XX tended to "XX" on XX when XX XX on it for a prolonged amount of time. On examination of the XX XX, XX had a positive XX compartment XX with XX XX. There was a positive XX XX laxity. XX XXwas noted. It was noted that, per work status report, XX. XX continued to work with restrictions.

X-ray of the XX XX dated XX/XX/XX was negative for definitive acute XX XX. An MRI of the XX XX was performed on XX/XX/XX. The study showed evidence of tearing of the XX XX of the XX XX s. Minimal amount of XX fluid was seen without overt XX effusion. There was slight XX of the XX XX XX compatible with a XX XX to the XX XX XX. X-ray of the XX XX dated XX showed possible trace XX change in the XX XX of the XX XX, which might be positional.

The treatment to date included medications (XX), XX , XX , XX XX, XX device, XX, and XX. XX. XX had failed all non-XX measures.

Per a letter dated XX/XX/XX , the request for XX XX XX with XX repair versus XX was denied by XX XX, MD. Rationale: "Per evidence-based guidelines, XX surgeries are recommended for patients with significant subjective complaints and objective findings corroborated by imaging report and after exhaustion of conservative care. While the patient presented with evidence of XX of the XX XX of the XX XX per MRI dated XX/XX/XX , significant clinical findings were limited to objectively evaluate the presence of XX XX . Moreover, detailed objective evidence of a recent, reasonable and comprehensive non-operative treatment trial and failure should be identified prior to considering the requested surgery. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Significant clinical findings were limited to objectively evaluate the presence of XX XX. Moreover, detailed objective evidence of a recent, reasonable and comprehensive non-operative treatment trial and failure should be identified prior to considering the requested surgery."

Per an adverse determination letter dated XX/XX/XX, the prior denial was upheld by XX XX , MD. Rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. During the peer discussion, it was asked about the XX XX tear. The PA stated they were not aware of any previous XX injuries. The provider is just concerned about the XX XX, and it is stated it is XX. XX has not been ordered, given the acute XX. The provider thought the injury was acute based on the patient's history. The patient does not meet the ODG criteria. There has not been formal documentation of XX and XX. The patient has signs and symptoms of XX changes, and there were no red flags or XX that this was a confirmed XX injury by MRI. Therefore, the request for XX XX XX with XX XX versus XX not medically necessary."

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

The ODG supports XX for symptomatic XX XX when there are ongoing mechanical symptoms and a failure of XX /XX XX XX. Additional criteria include XX pain, XX, XXXX XX, limited range of motion, positive XXXX , XX , or XX/XX /XX, and evidence of a XX XX on imaging. The documentation provided indicates that the injured worker has complaints of pain, instability, and XX in the XX XX which is worse with activity. A physical examination documented XX compartment XX with XX and XX compartment XX. An MRI of the XX XX documented a XX of the XX XX of XX XX, a partial tear of the XX XX XX, and x-ray documented possible trace XX changes in the XX compartment. The treating provider has indicated a diagnosis of XX XX XX XXand has recommended an XX XX versus XX repair. Previous treatment has included XX XX, XX XXXX ,XX , and XX XX.

Based on the documentation provided, the ODG would support the requested XX as there has been a documented trial and failure of conservative care and ongoing complaints of XX instability and XX with evidence of a XX XX XX on imaging. Therefore, the request is medically necessary and overturned.

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

ODG 2019: XX and Leg