# Independent Resolutions Inc.

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**IRO REVIEWER REPORT**

**Date:** 4/29/2019 3:02:17 PM CST

**IRO CASE #:** XX

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Revision of XX XX arthroplasty with XX X 3

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** Pain Medicine, Physical Medicine & Rehab

**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. XX was XX a XX to XX XX a XX XX XX after a XX XX at XX, and XX XX XX XX XX XX and XX XX. XX was diagnosed with pain in the XX XX (XX). The associated diagnoses were pain due to orthopedic XX devices, XX, and XX. On XX, XX. XX was evaluated by XX XX, XX / XX XX, XX. XX had some increasing problems and complaints in XX XX XX, but more pronounced on XX XX where XX had difficulty with activities of daily living. XX had a history of having a XX XX resurfacing. XX continued to have pain and complaints. XX continued to have XX pain on XX XX side as well. XX did continue to get nerve blocks by XX. XX, but XX XX XX was continuing to cause some exquisite discomfort. XX had to use a XX with XX and XX. The examination of the XX showed flexion of 90 degrees with sort of discomfort in the XX XX, and very limited mobility with range of motion and mobility. The plan was to proceed with revision arthroplasty. X-rays of XX XX dated XX showed XX XX resurfacings, no evidence of loosening, XX or XX, and no evidence of fracture. An MRI of the XX XX dated XX showed large areas of XX susceptibility artifact obscuring the entirety of the XX and XX XX. It was a markedly limited evaluation, given the extensive nature of the artifact. If there was an ongoing concern for XX / XX, this could be further evaluated via metal suppression CT as clinically warranted. There was XX. An electromyography (EMG) / nerve conduction study (NCV) of the XX XX XX dated XX showed electrodiagnostic evidence of a mild XX XX XX with some chronic changes in the anterior XX. There was no XX or XX. The treatment to date included medications (XX, XX, XX, XX, and XX) a XX, pain injections,

home exercise program, XX therapy, occupational therapy, and XX XX arthroplasty. Per a utilization review decision letter dated XX, the request for Revision of XX XX arthroplasty with XX days length of stay (XX) was denied by XX XX, XX. Rationale: "The presented objective findings were limited to fully support the need for the current procedure requested. Also, the X-ray of XX XX XX views dated XX showed XX XX resurfacings, no evidence of loosening, XX or XX, and no evidence of fracture. Moreover, exhaustion and failure from conservative treatment prior to considering revision total XX arthroplasty was not fully established. Furthermore, during the peer discussion with XX. XX, the provider stated that the patient had a million x-rays done. The previous surgery was discussed. Previous care included injections, seeing pain and rehabilitation provider, and medications. The patient reports persistent pain. The provider thinks it is a crapshoot on whether this would help, but notes the XX is XX and XX. The provider states this a diagnosis of XX. After this discussion, there was no indication as to the cause of the pain to the XX XX. There were no imaging studies to indicate loosening or failure of the components. As a result, it is unclear as to how this surgery will be beneficial and give the patient pain relief. Therefore, at this time, the requested procedure would not be deemed medically necessary. As the medical necessity of the requested procedure was not established, the requests for XX-day XX is also thereby not supported." Per an adverse determination letter dated XX, the prior denial was upheld by XX XX, XX. Rationale: "Significant clinical findings were insufficient to suggest recurrent disabling pain, stiffness, and functional limitation. There was no objective evidence of fracture or dislocation of the components, recurrent instability or aseptic loosening, XX fracture, and infection to meet the criteria and fully justify the need for this request. There was a concurrent request for XX x 3; however, the request for inpatient revision of XX XX arthroplasty is not indicated." In an addendum XX. XX stated that "I spoke with the provider. They stated the patient had persistent pain in the XX. Complete infection work up has been normal. The patient could have a loose XX component, it was stated. After the peer discussion, the previous appeal is again upheld. The patient does not have physical findings and lab findings definitizing and objectifying the diagnosis for the patient's pain. Therefore, the request is not supported."

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

The claimant had been followed for complaints of XX XX pain despite a previous XX. The records indicated no relief with other treatment to include injections, medications, a home exercise program, or therapy. However, the last imaging of the XX done in XX found no evidence of component loosening. Previous MRI studies of the XX XX were not helpful due to the poor quality of the study as a result of motion artifact. No other recent imaging of the XX XX was submitted for review documenting evidence of component issues to the extent that further surgery would be supported as reasonable or necessary. In review of the records, it is unclear if the benefits of further surgery exceeds the risks.

Therefore, it is this reviewer's opinion that medical necessity is not established and the prior denials are upheld.

**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