Core 400 LLC

An Independent Review Organization
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Review Outcome

Description of the service or services in dispute:

Outpatient XX XX partial medial XX repair.
XX (XX unit): Arthroscopy of XX, surgical, with XX medial or lateral

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

Board Certified Orthopedic Surgery

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 suffered an injury on XX. XX was XX a XX of XX and turned to the XX. XX XX and XX XX on the XX XX. XX placed the XX on the XX and XX felt some mild pain. XX noticed that while XX, the XX XX pain worsened. XX was diagnosed with other tear of medial XX, current injury, XX XX, initial encounter (XX.XX).

XX. XX underwent XX therapy re-evaluation by XX XX, XX on XX. XX was working full-duty at the time of the visit. This was considered to possibly reduce the ability of the XX XX to heal. XX had pain with quick transitioning motions, going up and down inclines, XX step-ups leading with the XX XX, going down the stairs, and deep squatting. The pain was rated 7-8/10 on standing or walking and 0/10 on sitting. The pain was stabbing in nature. On examination, there was 4+/5 strength for XX XX flexion. At the XX XX, there was decreased strength and pain on flexion and extension. XX test was positive on the XX side and there was tenderness to palpation at the medial joint line. Positive MRI findings were also present. The gait pattern had improved, but XX was very careful with transitional levels / uneven surfaces and pivoting due to increase in pain. XX had difficulty in climbing, walking, standing, crawling, squatting, crouching, stooping, pushing, pulling, XX, and carrying due to pain in the XX medial XX. Per XX. XX, XX. XX was unable to return to work full-duty at the time due to pain in the XX XX. The XX XX Components Scale score on XX was 89/100 (Extreme). The Lower Extremity Functional Scale raw score on XX was 5. The XX XX continued to be functionally limited with activities required for work such as squatting, XX XX, XX, and crawling. As confirmed by MRI, the XX XX presented with complex tear involving the posterior XX and body of the medial XX with undersurface and free-edge radial tears present making the earlier mentioned activities painful and difficult.

On XX, XX. XX was seen by XX XX, XX for the evaluation of XX XX XX. XX had been off-work since XX injury. XX had attended XX therapy and reported that it was helping XX range of motion. XX continued to have significant medial joint line pain especially with twisting / turning type of activities. On examination of the XX XX, there was a small effusion. The range of motion was 0 degrees to 135 degrees. There was tenderness to palpation over the medial joint line and proximal medial XX. The XX was stable to varus and

XX. XX and anterior drawer tests were negative. MRI of the XX XX was reviewed and showed complex tear of the medial XX with associated XX in the medial XX plateau. XX XX arthroscopy and partial medial XX was recommended.

An MRI of the XX XX dated XX showed complex tear involving the posterior XX and body of the medial XX. Undersurface and free XX XX XX were present. There was a XX XX displaced peripherally beneath the XX ligament. There was XX XX XX at the posterior medial corner of the XX plateau. Mild medial compartment XX was also seen. Moderate joint XX was noted. An x-ray of the XX XX dated XX had been negative for any fracture or dislocation.

The treatment to date included XX therapy and medications (XX).

Per a Prospective \ Concurrent Review Determination letter dated XX by XX XX, XX, the request for outpatient XX XX partial medial XX repair to include CPT code XX was not certified. The rationale for the denial was as follows: "Based on the medical records submitted for review, the claimant has continued pain in the XX XX. According to the guidelines, a XX is recommended after failure of conservative treatment to include XX therapy, when there are subjective complaints of joint pain and mechanical symptoms, and objective clinical findings of positive XX sign, joint line tenderness, and mechanical symptoms. Based on the records provided, the claimant is currently participating in XX therapy but has yet to complete a full course of conservative treatment as recommended by the guidelines. There is no positive XX sign on clinical examination. There are no subjective complaints of mechanical symptoms. The case was discussed with XX XX-XX, XX, who stated that authorization has been given to XX the peer-to-peer call on behalf of XX. XX. With clarification, the claimant has not completed therapy and has not had prescribed medications, nor have any findings been documented for being positive for significant intra-articular pathology to date. No additional clinical information was given. The request for outpatient XX XX partial medial XX to Include CPT Code XX is not certified."

Per a Prospective \ Concurrent Review Determination letter dated XX by XX XX, XX, the reconsideration request for outpatient XX XX partial medial XX repair to include CPT code XX was not certified. The rationale for the denial was as follows: "This is a noncertification of a request for reconsideration of a XX XX partial medial XX XX. The previous noncertification on XX, was due to lack of exhaustion of lower levels of care and lack of appropriate XX examination findings. The previous noncertification is supported. Additional records were not submitted for review. There should be exhaustion of lower levels of care, with appropriate XX examination findings, with imaging evidence of XX pathology. Treatment included XX and XX therapy with benefit to range of motion. The claimant continued with significant medial joint line pain, especially with twisting and turning. The XX examination documented a small joint effusion with range of motion of 0-135 degrees but no XX / XX instability. No posterior drawer was noted. There was tenderness over the medial joint line with MRI evidence of a complex tear of the medial XX with associated XX. The claimant has bone XX XX in the medial XX plateau posteriorly with mild XX of the medial compartment and complex tear of the medial XX body. There was not a diagnostic injection documented. There was no notation of buckling or give way of the XX. The request for reconsideration of a XX XX partial medial XX XX is not certified."

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 pathology when there is documentation of the tear, ongoing mechanical symptoms, and failure of conservative measures. The records available indicate failure of conservative measures with positive objective examination findings including joint line pain, swelling, and a positive XX maneuver. While there are not subjective complaints of mechanical symptoms, there is clear evidence of pathology on examination and imaging with the documented failure of conservative measures including oral NSAIDs and XX therapy. As such, progression to operative intervention would be warranted given the pathology present. 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:

Case Number: ***XX*** Date of Notice: 04/01/19

- ☐ 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
- ☑ 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 XX 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. XX 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.