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DATE OF REVIEW: December 2, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Authorization and coverage for surgical procedure of 1 XXXX XX XX release between XXXX.

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

M.D., Board Certified in Orthopedic Surgery.

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)

I have determined that the requested is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

This XXXX patient's physician has appealed the denial of the request for XXXX XX elbow release. The Carrier denied this request, indicating that the requested surgery was not medically necessary for treatment of the patient's medical condition. A review of records indicated that the patient was injured on XXXX. XXXX. The XXXX orthopedic report cited complaints of XXXX XX pain, XX, XX, and XX range of motion. Symptoms were aggravated by daily activities, lifting, pulling, pushing, and pressure. Symptoms were relieved with rest. XXXX reported XX pain that woke XXXX up. XXXX had pain with lifting objects and twisting the elbow.

Current medications included XXXX. A XXXX elbow exam documented no instability, full flexion, and XX-XX-degree lack of full extension. There was XX to palpation over the XX XX. XXXX elbow x-rays were obtained and demonstrated XX likely within the XX, medial aspect XXXX elbow. The diagnosis included XXXX elbow XX XX. The treatment plan documented a discussion of conservative treatment. Physical therapy was recommended. A XX injection was

performed to the XXXX XX XX. XXXX was placed on modified work. The XXXX orthopedic report indicated that the patient had been doing fair up to two weeks prior. XXXX reported exquisite XXXX elbow pain. XXXX elbow exam documented XX to palpation over the XXXX XX XX and XX. There was pain with resisted wrist and resisted long XX extension. There was no instability and range of motion was full. The treatment plan recommended a XXXX elbow MRI and continued modified work. XXXX was counseled regarding XX and XX.

The XXXX orthopedic report indicated that the patient had improvement in XXXX symptoms for about XX week following the injection. XXXX had continued to use XX and activity modification, but XXXX symptoms were XX. It was noted that repetitive use of XX XX and XX XX had contributed to XXXX injury. XXXX x-rays were normal. XXXX was restricted to no lifting greater than XX pounds with the XXXX hand and no pushing or pulling. An MRI had been recommended.

The XXXX elbow MRI impression documented evidence of XX XX with common extensor XX with XX thickening and surrounding XX, as well as XX thickness XX of the XX XX XX XX and XX XX XX. The XXXX orthopedic report cited complaints of XXXX XX pain, decreased range of motion, and XX. Current symptoms were reported XX and XX. Symptoms were aggravated by daily activities. XXXX reported the previous injection lessened XXXX symptoms very little. The XXXX elbow MRI on XXXX demonstrated XX XX and partial XX XX of the XX XX ligament. Current medications included XXXX. XXXX elbow exam documented XX-degree XX of full extension, full flexion, XX over the XX XX and insertion of the XX, XX grip strength, and pain with resisted XX XX with XX/5 strength. The diagnosis was XXXX XX XX. The patient was experiencing XX XX issues and wanted to try to avoid XXXX XX surgery. XXXX was restricted to lifting less than XX pounds with the XXXX hand. XXXX was given a prescription for XXXX.

The XXXX orthopedic report cited current mild to moderate symptoms with activities, and weakness. XXXX reported symptoms were aggravated by daily activities, and relieved with rest. Current medications included XXXX. XXXX elbow exam documented XX-degree lack of full extension, full flexion, XX over the XX XX and insertion of the XX, XX grip strength, and pain with resisted wrist extension with XX/5 strength. The diagnosis included XXXX elbow XX XX. The patient had failed conservative management for many months and wanted to consider XX intervention. Authorization was requested for XXXX XX XX release. The XXXX utilization review non-certified the request for XXXX XX elbow release. The rationale stated that guidelines did not support proceeding with XXXX XX elbow release surgery before completing XX months of conservative treatment. The XXXX utilization review non-certified the appeal request for XXXX XX elbow release. The rationale stated that there were no significant extenuating circumstances to shorten the Official Disability Guidelines recommendation for XX months of conservative treatment.

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

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This patient presents with current complaints of mild to moderate XXXX XX symptoms, including pain, XX, and XX range of motion. Functional limitations have been reported in work activities, although records have documented a progressive decrease in work restrictions with no apparent lack of XX. XXXX elbow exam is consistent with imaging evidence of XX XX and common extensor XX with mild XX and surrounding XX, as well as partial XX XX of the XX XX XX ligament. There is detailed evidence of XX months of conservative treatment to include XX, XX injections, and activity modification, plus limited evidence of XX, exercise, and physical therapy. The Official Disability Guideline criteria have not been met to support surgery for XX XX. While the patient has persistent symptoms, there is a documented progressive decrease in work restrictions with no clear evidence that XXXX has failed to tolerate the decrease. Additionally, the patient is XXXX months status postdate of injury. There is no compelling rationale presented or extenuating circumstances to support an exception to guidelines that typically require XX months of failed conservative treatment prior to surgical consideration.

Therefore, this request for XXXX XX elbow release is not medically necessary 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**
- ☐ **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 (PROVIDE A DESCRIPTION)**