Vanguard MedReview, Inc.

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November 14, 2018, amended November 28, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

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A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: This case was reviewed by a Board-Certified Doctor of Orthopedic Surgery with over 18 years of experience.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

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

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX: Office Visit by XXXX. **HPI:** Patient is a XXXX who presents with XX pain. The injury is involved in the XX. This occurred at work. Symptoms include XX pain and XX in XX XX. Pain is XX. Moderate in severity and unchanged. Pain is exacerbated by movement and use of XX. XXXX also complains of occasional XX XX. **Exam:** No instability or laxity, non-known fractures or deformities and normal laceration over the XX aspect of the XX wrist with contracture of the scar. Functional testing: Axial load test XX, grind test XX, Two point discrimination XX. Wrist flexion functionally XX. **Assessment/Plan:** XX of XX wrist. Problem: XX; XX XX over the XX aspect of the XX wrist with XX of the XX. This patient sustained a XX at work XXXX months ago and had it repaired. XXXX clinical exam findings show concern for a XX. We will order an MRI to evaluate for XX versus XX/XX injury. The patient will follow up after MRI. The patient may benefit from a XX XX surgery. Patient may return to work with restriction to remain non-weight bearing with XXXX XX XX XX.

XXXX: MRI XX Wrist without contrast interpreted by XXXX. **Impression:** XX XX along the XX XX aspect of the XX without an underlying XX injury nor evidence of an underlying XX XX collection.

XXXX: Office Visit by XXXX. **HPI:** Patient presents for MRI results. XXXX rates pain at XX/10. XXXX is not taking med for pain. **Assessment/Plan:** This patient sustained XX XX XX across the XX that has healed with significant XX resulting in a XX XX on XX XX aspects of XX which is limiting extension of the XX. I feel this patient will need XX to improve. The procedure was explained in detail to the patient and all risk and benefits were reviewed. The patient wishes to proceed with XX. The plan will be XX XX XX revision, XX-XX of the XX, and XX of flexor XX XX XX. Patient may return to work without restrictions.

XXXX: UR performed by XXXX. **Rationale for Denial:** As per ODG "XX." In this case, this is a XXXX who sustained an injury on XXXX. The patient has persistent XX XX pain and XX. Examination revealed limited functional strength to the XX XX and XX. However, there is no detailed evidence of weeks-month(s) of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure submitted. There is limited objective evidence of a contracture on examination to support this request. Therefore, this request would not be considered medically reasonable and necessary at this time.

XXXX: UR performed by XXXX. **Rationale for Denial:** There is no additional documentation to support the requested XX procedure such as a thorough examination with deficits, range of motion or functional deficits.

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

The request for XX XX XX revision and XX is denied.

The patient is a XXXX who sustained a XX XX in XXXX. The treating physician is concerned that the patient has developed a XX XX, which has resulted in limited XX extension. XXXX has recommended XX revision with XX of the flexor XX XX XX.

A close review of the records demonstrates no documentation of XX range of motion (active and passive) or specific functional deficits. It is unclear whether the patient has responded to any non-operative treatment, such as occupational therapy or XX.

Based on the medical records, XX XX XX revision is not medically necessary, therefore the patient is not a surgical candidate.

Per ODG:
XX

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)**