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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XXXX XX row XX and XX XX and surgical assistant

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

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]:

XXXX. The ongoing diagnoses included traumatic XX other ligament of the XXXX XX, initial encounter (XX.XX), pain in the XXXX XX (XX.XX), and complex XX of XX XX, current injury, XXXX XX, subsequent encounter (XX.XX), and unspecified sprain of XXXX XX, subsequent encounter (XX.XX). XXXX underwent diagnostic XXXX XX XX, partial XX, XX / XX compartment XX and partial XX of XX pad, and simple closure on XXXX. XXXX was seen by XXXX for XXXX XX pain. Examination of the XX revealed XX and XX of the XX XX on the XXXX. There was tenderness of the XX XX, the XX XX, and the XX XX. Watson's shift test was XX. XXXX recommended XX row XX and XX X. An MRI of the XXXX XX dated XXXX showed the XX ligament was XX with XX of the XX space to XX mm. There was mild XX change and XX with some XX bony changes along the XX pole of the XX. Slight XX migration of the XX and mild XX XX of the XX were noted. There was moderate-to-severe radial XX XX and XX. There was also mild XX to the XX aspect of the XX proximally with small XX XX likely related to XX and neutral XX variance. The treatment to date included medications (XXXX), XX therapy, XX, XX injection on XXXX, XX therapy, XXXX XX XX partial XX, XX, XX on XXXX. Per a utilization review decision letter dated XXXX and a peer review, the requested service of the XXXX proximal row XX and XX XX and surgical assistant was denied by XXXX. Rationale: "Based on the clinical information submitted for this review and using the

evidence-based, peer-reviewed guidelines referenced above, this request is noncertified. Medical reports submitted were limited to validate utilization of conservative treatments prior to considering surgery. Furthermore, there was no imaging submitted to validate findings. Exceptional factors were not identified." Per a utilization review decision letter and a peer review dated XXXX, the requested service of the XXXX proximal row XX and XX XX and surgical assistant dated XXXX. 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. The objective findings were limited to verify stage XX XX XX. Furthermore, medical reports were limited to validate compliance, failure, and exhaustion of lower levels of care prior to considering surgery".

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

XX. The provided documentation reveals evidence of persistent XXXX XX pain approximately XX months out from injury despite treatment with XXXX and XX therapy. There are XXXX XX MRI findings of a XX XX ligament, XX of the XX space, XX change and XX XX changes of the XX pole of the XX, slight XX migration of the XX, mild XX XX of the XX, moderate to severe XX XX XX and XX, and mild XX of the XX aspect of the XX proximally with small XX XX. These MRI findings are consistent with stage XX XX XX and when noting that the ODG does not recommend XX for stage XX XX XX, the procedure is not medically necessary. It is unclear why XX would be necessary in addition to the XX when it is usually used as an alternative to surgery.

Based on the provided documentation and ODG recommendations, the request is not medically necessary and therefore upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM- AMERICAN COLLEGE OF XX & 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