# True Decisions Inc.

**An Independent Review Organization**
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**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**
XX XX XX XX and XX inpatient days

**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 were sprain of the XX, XX and XX sprain, and chronic pain following XX XX. XXXX provider requested XX XX, XX and XX compartments (XX) and XX days of inpatient stay for the diagnosis of pain in the XX XX (XX) and XX primary XX of the XX XX (XX). Per an office visit note by XXXX, XXXX was getting an injection in XXXX XX XX when XXXX had a XX reaction to the injection and XXXX. XXXX had many injuries, including XX, XX, XX XX. XXXX had undergone XX XX XX on XXXX that described XX XX and XX XX of the XX compartment. Examination of the XX XX was XX for XX and XX XX XX pain. XX were XX XX XX examination noted a XX, positive XX XX XX pain, negative effusion, good endpoint to XX, XX, range of motion 0-110 degrees XX and XX, negative XX XX, negative XX, negative XX, XX, and XX and XX negative. XX examination revealed XX pain to XX of the XX XX and positive XX. XX examination revealed pain to XX of the XX XX, positive XX XX, and an XX XX XX XX. The assessment was XX, XX XX XX XX XX, XX at XX-XX, XX-XX, XX-XX, XX-XX, and XX-XX, and XX XX at XX and XX. On XXXX, XXXX visited XXXX for the chief complaints of XX XX pain, status post XX total XX XX, XX XX XX, XX pain, and XX pain. Examination and assessment were unchanged from prior. An XX of the XX XX dated XXXX, demonstrated advanced XX and XX blunting / tear. Treatment to date included medications including XXXX and XX intervention. Per a utilization review dated XXXX denied the request for XX XX with XX-day inpatient stay to be performed at XXXX as not medically necessary or appropriate. Rationale: "A peer-to-peer discussion was not established. With regard to the request for a XX, this request is not supported. Despite the claim that the patient had undergone a XX XX, XXXX was not over the age of XX years as indicated by the guidelines as

part of the criteria for undergoing this particular XX. Furthermore, there was no documentation of the patient having obtained standing x rays noting significant loss of XX XX XX in at least XX of XX compartments, Moreover, patients must have XX of the XX compartments affected by significant XX to support total XX. Additionally, the physician did not address that the patient had failed to respond to all listed conservative treatment measures to include XX XX-XX drugs or XXXX injections with no record of the patient having trialed recent XX injections. Based upon these findings, it was determined that proceeding with XX would not be within guidelines standards of care. Therefore, although XX days inpatient stay is the best practice target following XX, at this time, the requested services cannot be authorized. As such, the request for XX XX and XX inpatient days to be performed at XXXX is non-certified. Because an adverse determination for surgery has been rendered, an adverse determination for any associated pre-operative clearance is also rendered." Per a utilization review dated XXXX, an appeal of the denial was received on XXXX. This was reviewed and the appeal request for XX XX with XX-day inpatient stay to be performed at XXXX was denied. It was determined that the request still did not meet medical necessity guidelines. Rationale: "A peer-to-peer discussion was unsuccessful despite calls to the doctor's office. The ODG recommends XX when there has been a failure to improve with conservative treatment, there are subjective findings of stiffness, nighttime joint pain, marked daily pain and significant functional limitation, an XX over XX and the XX, and evidence of advanced XX on imaging. The ODG states that the best practice target Hospital length of stay following XX is XX days. The provided documentation reveals a XX of XXXX and evidence of XX on XX with the involvement of all XX XX compartments; however, the provided documentation does not discuss conservative treatment, and the most recent provided note from XXXX, does not document subjective complaints regarding the XX XX. Based on the lack of documentation, the XX XX XX and XX inpatient days is not medically necessary. Recommend non-certification."

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

In review of the provided records, this is a XX patient with ongoing XX XX pain. The claimant's imaging did not demonstrate evidence of sufficient XX in the XX XX to warrant a XX for a patient XX of XX. No exceptional factors were noted. Therefore, it is this reviewer's medical assessment 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