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10/29/XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX partial XX

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

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]:
This case involves a XXXX with a history of an outpatient claim from XXXX. The mechanism of injury was detailed as occurring when patient was XXXX. The current diagnoses are documented as XX XX pain and XX XX. The XX of the XX XX from XXXX revealed XX XX.

The clinical note from XXXX notes that the patient had a chief complaint of XX pain to the XX XX. The pain is described as XX and associated with XX swelling. The patient has been treated with XX XX-XX drugs. On examination of XX XX, the patient had pain with range of motion with XX XX degrees and extension 0 degrees. There was XX joint line tenderness. The patient had a edial XX's test and XX. The treatment plan is for the patient to undergo a XX XX XX XX.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The guidelines indicate that conservative treatment including exercise/XX therapy and medication, or activity modification should be completed prior to the requested surgery. The patient needs to have findings of XX pain, XX. The patient also needs to have objective clinical findings to include positive XX sign, XX line tenderness, XX, limited range of motion or XX. There needs to be evidence of a XX XX on XX. The documentation indicates that the patient had continued complaints pain despite XX XX-XX XX use. The patient had complaints of XX pain as well as positive XX sign on examination. The patient did have findings of a XX XX on XX. However, there was no indication that the patient has previously undergone conservative

treatment including XX therapy prior to requested surgery. Therefore, the requested XX XX partial XX is non-certified and not medically necessary.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), XX, XX and XX, XX

ODG Indications for Surgery™ -- XX:

XX

- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**