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An Independent Review Organization
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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX

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 who was diagnosed with XX primary XX of the XX and XXXX. XXXX sustained an injury on XXXX while at XX. XXXX. XXXX had XX torn XX XX. XXXX was evaluated on XXXX for XX XX pain, XX worse than XX. XXXX reported a XX-month history of progressively increasing pain in XXXX XX rated at XX/10. The pain was worse with XX. XXXX described the pain XX, and XX and XX. On examination, XX XX showed XX – XX correctable. The range of motion was XX. There was mild XX. There was XX to XX at the XX joint line and XX. Less than XX was noted. XXXX was seen on XXXX for constant XX XX pain, XX more than XX. The pain increased with XX, and XXXX. The XX XX was XX and had given out once. On examination, XXXX XX independently with a minimally XX XX. On XXXX, an MRI of the XX XX showed a XX of XX of the XX with a probable displacement of the XX to XX, XX; XX compartment and XX XX with XX cartilage XX; XX about the XX and XX joint compartment; XX XX defect involving the XX, which measured; XX defect seen within the XX aspect of XX and high-XX seen involving the XX XX XX extending to the XX ridge. An XX of the XX XX revealed XX, preferentially involving the XX joint; XX and XX XX XX XX XX; XX XX XX. Treatment to date included medications with some relief (XXXX) and XX therapy. Per a Notification of Adverse Determination dated XXXX, the requested service for XX total XX XX XX was non-certified. Primary reasons for determination: "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 support the need for

surgery as there was no objective documentation of XX. XXXX was not over XXXX years of age. Furthermore, the confirmation on whether the patient really failed conservative treatments was not established as actual XX therapy reports were not submitted for review and there was a lack of documented objective patient response from medications. Lastly, XX is not recommended based on the lack of evidence showing improved clinical outcomes. Exceptional factors for use were not identified." Per a Notification of Reconsideration Adverse Determination dated XXXX, the appeal for XX total XX was non-certified. Primary reasons for determination: "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 still limited to support the need for XX as there was no objective documentation of XX. XXXX was not over XXXX years of age."

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

In review of the records provided, the claimant has not done much in the way on non-operative management, including XX injections without a good reason as to why. The claimant is XX XX for a XX, and without having exhausted non-operative measures, the surgical request is excessive without clear exceptional reasons which were not evident in the records.

Therefore, it is this reviewer's opinion that the request is not medically necessary, 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