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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX XX with extensive XX, XX, XX and 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

Recommendation is that the previous denials be partially overturned with overturning the previous denials for the requested XX XX XX with extensive XX of the XX XX XX XX (XX), XX procedure, and XX of the XX XX XX XX XX. Given the documentation available, the requested service(s) is considered medically necessary.

Recommendation is for upholding the previous denials for the requested XX XX removal. Given the documentation available, the requested service(s) is considered not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX. The diagnosis was XX XX of the XX XX. XXXX for a recheck of XX XX pain and to discuss the denial of surgery. The pain was XX. It was characterized as a XX (with movement) pain. The pain affected the XX XX and was relieved by medication XXXX. XXXX also had XX. Prior diagnostic tests included plain XX. There had been prior evaluations by urgent care personnel. There was no previous physical therapy performed. There had been no prior XX. XX devices included XX. The pain was noted to be XX/XX at the time. On examination, there was decreased strength of the XX muscles (XX/5) at the XX XX XX. There was pain with resisted XX and with resisted XX. XXXX continued to have activity limiting XX pain, which had failed conservative treatment including medicine, therapy, XX, and XX injections. XXXX opined that surgical intervention was necessary. XXXX was cleared to return to work with a restriction of no lifting over XX pounds. An MRI of the XX XX dated XXXX revealed mild XX of the common XX XX origin without a XX tear, and mild XX XX. A diagnostic ultrasound of the XX XX dated

XXXX showed a XX on the XX XX. The XX XX was visualized and noted to have some XX along the XX near the XX surface. The XX structures were unremarkable. The treatment to date included XX, XX injections (was doing better with it), medications XXXX and a XX. Per an initial utilization review adverse determination letter dated XXXX, the request for XX XX XX with extensive XX of the XX XX XX XX (XX), XX Procedure, XX XX removal and XX of the XX XX XX XX XX was denied. The rationale was as follows: XX. In this case, the objective clinical findings were limited to suggest persistent symptoms interfering with activities that would justify the need for this XX intervention. Furthermore, there was no clear evidence that the patient had exhausted conservative therapy as there were no objective response specific from the treatment rendered." The Primary Reason(s) for Determination was: "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 clinical findings were limited to suggest persistent symptoms interfering with activities that would justify the need for this surgical intervention. Furthermore, there was no clear evidence that the patient had exhausted conservative therapy as there were no objective response specific from the treatment rendered." Per an appeal adverse determination dated XXXX, the requests for XX XX XX with extensive debridement of the XX XX XX XX (XX), XX procedure, XX The Primary Reason(s) for Determination was the following: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, surgery for XX is indicated for patients with persistent symptoms that interfere with activities that have not responded to an appropriate period of nonsurgical treatment. In this case, the patient continued to have XX pain with XX and pain with XX. Per recent medical, XXXX continued to have XX-XX XX pain, which had failed conservative treatment including medicine, therapy, XX, and XX injections; however, there was limited evidence of at least XX-month compliance and exhaustion of conservative measures and failure from conservative measures. After speaking with XXXX and designee, XXXX stated the patient was first seen in XXXX. The patient had injections, XX sessions of therapy, XX, and medication, with no relief. The patient complains of XX and continued pain after conservative treatment. Regarding the XX XX, this was put in anticipation based on the imaging studies. The designee stated there is a XX on the XX XX tendon. The patient does not. Specifically, the patient does not have the physical findings, symptoms, or enhanced imaging to support the need for XX XX, therefore, the entire request is not medically necessary." Per an appeal adverse determination letter dated XXXX the requests for XX XX XX with extensive XX of the XX XX XX XX (XX), XX procedure, XX XX XX and XX. The rationale included the following: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, surgery for XX is indicated for patients with persistent symptoms that interfere with activities that have not responded to an appropriate period of nonsurgical treatment. In this case, the patient continued to have XX pain XX and pain with resisted XX XX and resisted XX. Per recent medical, XXXX continued to have XX-XX XX pain, which had failed conservative treatment including medicine, therapy, XX, and XX injections; however, there was limited evidence of at least XX-month compliance and exhaustion of conservative measures and failure from conservative measures. After speaking with XXXX and designee, XXXX stated the patient was first seen in XXXX. The patient had injections, XX sessions of therapy, splinting, and medication, with no relief. The patient complains of weakness and continued pain after conservative treatment. Regarding the XX XX, this was put in anticipation based on the imaging studies. The designee stated there is a XX on the XX XX

tendon. The patient does not. Specifically, the patient does not have the physical findings, symptoms, or enhanced imaging to support the need for XX XX, therefore, the entire request is not medically necessary.

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

The ODG recommends surgery for chronic XX after a XX-month failure of conservative treatment with XX, XX XX/XX, activity modification, and XX therapy. The ODG states that any of the three XX surgical approaches (open, percutaneous and arthroscopic) are acceptable. The provided documentation revealed evidence of persistent XX XX pain nearly XX year out from injury despite treatment with XX, a XX, injection, XX, a XX XX XX, and XX sessions of XX therapy. There are physical examination findings of a XX XX XX test and pain with resisted XX XX and resisted XX. There are MRI findings consistent with XX XX. There are no MRI findings consistent with a loose body. Given the duration of symptoms, failure to improve despite exhaustive conservative measures, pertinent objective findings on physical examination, and pertinent MRI findings, the requested XX XX XX with extensive XX of the XX XX XX XX (XX), XX procedure, and XX of the XX XX XX XX XX are supported. As there is no evidence of a XX XX, the proposed XX XX XX is not supported.

Recommendation is that the previous denials be partially overturned with overturning the previous denials for the requested XX XX XX with extensive XX of the XX XX XX XX (XX), XX procedure, and XX of the XX XX XX XX XX. Given the documentation available, the requested service(s) is considered medically necessary. Recommendation is for upholding the previous denials for the requested XX XX removal. Given the documentation available, the requested service(s) is considered not medically necessary.

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