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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Purchase of XX for the XX XX to be used following XX 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]:
The patient is a XXXX. XXXX. The diagnoses included XX XX sprain (XX) and XX XX XX (XX). On XXXX, XXXX presented to XXXX for XX pain and XX XX pain. XXXX reported constant XX/10 XX and XX pain. The symptoms were aggravated by activity and alleviated by nothing. It was noted that XXXX had undergone an XX injection at XX-XX. XX examination was remarkable for mild limitation of range of motion secondary to pain. The XX XX was XX due to injury. Sensation was normal to light touch from XX to XX. There was XX XX present of the XX XX muscles. The XX of the XX XX was reviewed. The assessment was XX pain, XX XX, XX XX of the XX, XXXX, and XX XX of the XX region. XXXX recommended that XXXX undergo surgery, as XXXX had failed conservative care. XXXX evaluated XXXX on XXXX for ongoing XX pain that was localized to the XX XX region and had been present for XX. It was XX/10 in severity and radiated to the XX XX distribution. The pain was described as XX. XXXX was utilizing XXXX XX. XX of the XX XX was reviewed and interpreted as showing ruptured XX at XX-XX, XX-XX and XX-XX. On XXXX, XXXX reported XX, XX XX, and XX XX pain that was constant, XX alleviated by rest. The diagnoses were XX pain and XX XX. On XXXX, it was noted that XXXX had tried XX therapy, pain medicine, and XX XX injection with no significant benefit. XXXX now reported a worsening of symptoms. XX examination showed XX limitation of range of motion secondary to pain. XX test, XX sign, and XX abduction test were negative XX. XXXX were refilled. On XXXX, XXXX noted XXXX was still having a lot of pain and continued XX XX numbness and tingling. A XX XX dated XXXX showed central XX protrusions from XX through XX resulting in moderate secondary XX at XX-XX and XX-XX.

There was moderate canal XX at XX-XX, mild secondary XX XX XX XX at XX-XX, and XX XX protrusion at XX-XX, XX-XX, and XX-XX. Moderate XX XX XX at XX-XX was noted along with severe XX at XX-XX and XX-XX with early XX. An XX study of the XX XX extremity dated XXXX was normal. There were no XX findings for a XX XX or XX. Treatment to date consisted of medications (XXXX), XX therapy (with some relief), two XX XX shots, two XX packs, and one XX XX XX injection. A designated doctor evaluation was completed by XXXX. XXXX opined that the XX XX at XX-XX and XX-XX were caused or aggravated by the mechanism of injury in question, and these XX protrusions had caused both XX and XX XX. If XXXX underwent surgical intervention in a timely fashion as well as appropriate ODG-allowable XX care, XXXX would reach maximum medical improvement on or before XXXX.A Peer Review Clinical Report was completed by XXXX. Recommendations and clinical rationale were as follows: "Based on available information and the ODG Guidelines, the requested XX-XX XX is not medically necessary. The following are the reasons for my recommendation for non-certification. In XXXX note, XX days prior to XXXX note, there is no mention of XX pain. XXXX describes XX and XX XX pain along with intermittent numbness in the XX "XX" distribution. It is not clear whether the symptoms could be related to an XX XX. XXXX's most recent note of XXXX assessed the injured worker as having XX pain and a XX XX. The history provided in that note, and in XXXX prior notes are insufficient to support a diagnosis of a XX. ln the XXXX note, there is no detail regarding the distribution/location of the XX XX pain. The frequency of the XX pain, the duration of the XX pain, etc. In the XXXX note, there is no mention of XX XX pain except in XXXX conclusion. On XXXX, there is mention of XX pain but no further detail. In speaking with XXXX, XXXX stated the injured worker had XX and XX XX pain but no XX pain. This conflicts with some of XXXX notes. XXXX stated the injured worker had XX involving the entire XX XX, XX, and all the XX. There is only mild XX XX XX at XX-XX, so it is unlikely that the injured worker has a XX XX. A XX XX would not cause XX in the XX or any XX. In the most recent exam by XXXX on XXXX, there are no objective findings of a XX, i.e., the injured worker had normal strength, sensation and reflexes. This conflicts with the earlier XXXX note in which surgery was recommended 'for XXXX severe XX XX pain and progressive XX of XXXX 'dominant XX.' While the XXXX XX showed moderate XX XX XX at XX-XX because of the vague and contradictory histories, it is not clear that the injured worker is symptomatic from the XX. There is only mild XX XX XX at XX-XX. Given that the XX XX on the XX is mild at this level, there is unlikely to be nerve compression to cause a XX radiculopathy. While there is moderate-to-marked canal XX at XX-XX and XX-XX, there is insufficient history suggestive of a symptomatic XX and no documented exam findings of a XX to suggest that the injured worker is symptomatic such that surgery is indicated." A subsequent report dated XXXX indicated: "I am recommending non-certifying the requested purchase of XX XX XX for the XX XX to be used following XX XX. Given non-certification of the requested surgical procedure, medical necessity of a post-op purchase of XX XX XX for the XX XX to be used following XX XX is not indicated. Per a utilization review dated XXXX, the request for purchase of XX XX XX for the XX XX to be used following XX XX was non-authorized. Explanation of findings: "I am recommending non-certifying the requested purchase of XX XX XX for the XX XX to be used following XX XX. In conjunction to this utilization review, there was also a review completed regarding the medical necessity of the XX-XX XX XX XX and XX, which I deemed to be not medically necessary. Given non-certification of the requested surgical procedure, medical necessity of a postop purchase of XX XX XX for the XX XX to be used following XX fusion is not indicated. Therefore, the request is non-certified. A Peer Clinical

Review Report was completed by XXXX. XXXX noted that XXXX reported the pain in the XX XX down the XX XX and was rated as an XX/10 on the pain scale. XXXX had XX therapy and an XX XX injection with no significant benefit. Findings included limited XX range of motion secondary to pain. There was no clear objective documentation of XX deficits in the XX through XX distribution indicative of the XX. Therefore, XXXX recommended non-certifying the request for XX-XX XX XX XX and XX. Given that the request for XX-XX XX XX XX and XX had been recommended for non-certification, XXXX recommended non-certifying the request for purchase of XX XX XX for the XX XX. Per a utilization review dated XXXX, the appeal for the purchase of XX XX XX for the XX XX to be used following XX fusion was non-authorized. Explanation of findings: "Given that the request for XX-XX XX XX XX and XX has been recommended for non-certification, I am recommending non-certifying the request for purchase of XX XX stimulatory for the XX XX."

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

The ODG does not support the use of XX XX XX as there is conflicting evidence regarding efficacy. Criteria for their use for case-by-case recommendations include: one or more previous failed XX XX; grade XX or worse XX; fusion to be performed at more than one level; XXXX which has been demonstrated on radiographs. The documentation provided indicates that the provider has recommended a XX XX and XX XX XX. The most recent utilization review regarding the XX XX which was completed on XXXX indicates that the requested XX-XX XX XX XX and XX and XX XX have been recommended for noncertification. A utilization review dated XXXX also indicates that the XX XX for the XX XX following XX fusion was not authorized. Based on the documentation provided, which indicates that the injured worker has not been approved for XX fusion, and while the ODG would support the use of postoperative XX XX XX as the XX is recommended for XX levels, given the absence of certification for the fusion, there is no indication that a XX XX XX would be required without the associated surgical intervention. The prior denial for the XX XX XX is not medically necessary and should be upheld at this time as the proposed XX intervention has been shown to be 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 XX XX 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

ODG, 2018: XX and XX XX XX-XX stimulators (XX) Under study. See the XX XX Chapter for more information about use in XX fusion.