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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX XX, XX repair

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 injured on XXXX. XXXX. The ongoing diagnoses included XX, XX XX (XX); pain in XX XX (XX); pain in XX XX (XX); and other tear of XX, current injury, XX XX, XX XX (XX). XXXX for the XX XX pain. XXXX had been having XX XX pain for over XXXX months. XXXX noted XX and XX in the region. The symptoms were aggravated with walking, standing, and twisting. They were relieved by nothing. The pain was XX/10. Examination of the XX XX revealed XX alignment. The range of motion was XX degrees. There were XX joint line XX and a XX of the XX compartment the XX. XX was positive XX compartment the XX. An XX of the XX XX without contrast was performed on XXXX. There was joint XX over XX XX. XX XX was noted. The treatment to date included medications (XXXX), XX, rest, activity modification, home exercise program, and XX therapy. XXXX had failed all conservative options. Per a utilization decision letter dated XXXX, the requested service was denied by XXXX with the following rationale: "Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. There were limited medical reports submitted to validate compliance, exhaustion, and failure of lower level of care as there was only the initial XX therapy evaluation submitted. Furthermore, medical reports submitted had no evidence of significant progression of symptoms to warrant the need for the request. In addition, there was limited documentation of significant functional limitations and alterations of activities of daily living to

warrant the need for surgery. The exceptional factors were not identified." On XXXX wrote an appeal letter. XXXX requested a XX, XX versus repair. Per a utilization review decision letter dated XXXX, the reconsideration request was denied by XXXX. Rationale: "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 provision of non-operative treatments still cannot be established in the medical reports submitted. Actual evaluation or a progress treatment / therapy reports were still not submitted to validate if the patient was unresponsive or had failed treatments. The prior non-certification is upheld."

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

The ODG supports XX for traumatic XX patients when the following criteria have been met: XX. The documentation provided indicates that the injured worker has ongoing complaints of XX XX pain and XX. A XX examination indicates XX joint line XX and positive XX indicates a XX. The provider documents a trial and failure of XXXX, rest, activity modification, and exercise/XX therapy. The provider recommends a XX XX XX versus XX. The initial utilization review indicated that there is insufficient information available to document failure of conservative treatment. The reviewer indicated that there was only an initial XX therapy evaluation available and there is no evidence of progression of symptoms to warrant proceeding with surgical intervention. The XX indicated that conservative treatment had reportedly been exhausted, but XX therapy notes were not available; however, the documentation from the treating clinician clearly indicates that XX therapy was attended without an improvement in symptoms and there are ongoing mechanical complaints. Based on the documentation provided, the XX would meet ODG criteria for an XX. The XX has tried and failed all conservative measures, has complaints of pain and locking, there XX tenderness and a positive XX on exam, and XX of a XX tear.

As such, the requested XX is medically necessary and the prior denials are overturned.

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