MEDRX

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DATE OF REVIEW: April 23, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
XX XX distraction arthroplasty versus arthroplasty: XX, XX, XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒Upheld (Agree)

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the medical necessity of: XX XX distraction arthroplasty versus arthroplasty: XX, XX, XX

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant has a long history of injury and complications in the XX XX. The first mention of difficulty occurred in XX with a surgery to clean out an XX. XX was XX years of age at the time. Since that time, XX has had flares of pain, but XX has been working at a XX XX. This compensable injury occurred when XX XX and XX the XX while working. XX had an immediate onset of severe pain. XX had a period of XX therapy without much improvement. XX has had x-rays that showed a complete loss of joint space in the XX joint. An MRI showed

moderate to marked obliteration of the joint space along with XX XX from chronic XX changes and multiple XX ruptures.
XX consulting orthopedic surgeon at XX XX has recommended a distraction arthroplasty. The doctor states that a fusion would not be acceptable to the claimant due to XX work.

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

XX XX Distraction Arthroplasty is not medically necessary and is non-certified.
According to the ODG, candidates for Distraction XX Arthroplasty Surgery must meet ALL of the following criteria:
1) XX

XX. Therefore, the requested procedure is not medically necessary and is non-certified due to not meeting requirements established by the ODG and by the XX and XX Surgeons.

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**
- ☐ **AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**

☐ **TMF SCREENING CRITERIA MANUAL**

☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**