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IRO REVIEWER REPORT

Date: 4/17/XX 2:18:23 PM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX XX XX fusion

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]: XX. XX XX is a XX-year-old XX who was injured on XX, where XX sustained a XX injury. The diagnosis was displaced unspecified XX of the XX XX XX, subsequent encounter for XX with malunion (XX.XX). A CT scan of the XX XX was performed on XX for a history of prior XX XX XX. The study demonstrated XX XX XX related to old healed XX XX XX. XX. XX was evaluated by XX XX, XX on XX for a follow-up on XX XX XX XX injury with a proximal XX malunion that XX sustained on the job on XX. XX reported progressively worsening pain. XX was unable to work. XX was unable to XX a XX-XX XX. XX recently had a CT scan, and presented for the results. On physical examination, XX was noted to XX on XX XX XX XX in a postoperative XX. The XX XX had some diffuse swelling. There was tenderness near the XX joint where there was a XX. There remained some XX XX XX. XX. XX opined that XX. XX was not responding to nonoperative management and complained of significant pain and XX. XX would need a XX XX fusion to help with XX pain and XX and to allow XX to hopefully return to work in a closed-XX XX without problems. Per a utilization review determination letter dated XX, the request for XX XX XX fusion was denied by XX XX, XX with the following rationale: "The records submitted for review would not support the requested procedures as reasonable or necessary. In the review of the provided records, there is ongoing pain and mild swelling at the XX XX. However, no imaging studies were submitted for review. It is also unclear what prior non-operative measures were completed to date. Without additional clinical information, this reviewer would not recommend certification for the requested XX XX XX fusion. A peer-to-peer discussion was unsuccessful despite calls to the doctor's office. Conversations between the requesting provider and the reviewing physician, if any, may provide additional information for the reviewing physician to consider; however, a lack

of a successful peer-to-peer conversation does not result in an automatic adverse determination. Utilization review decisions are based on evidence-based guidelines and the medical documentation submitted for review. Addendum: I spoke to XX who is XX. XX's medical assistant on XX at XX XX. Per our discussion, XX stated that the XX is healed but with an angular XX. The patient underwent a CT study in XX of XX. No other information was provided to support altering the determination." Per an appeal review determination letter dated XX, the request for XX XX XX fusion was denied by XX, with the following rationale: "The requested surgery was previously denied due to a lack of documented conservative care modalities, and lack of imaging reports provided for review. Although the request was submitted for an appeal, with an included CT scan of the XX XX revealing an angulation XX, there was still no description of prior conservative management as required by guidelines, including immobilization, XX, XX, XX modification, and anti-inflammatory medication use to support proceeding with surgery. Therefore, XX XX XX fusion, date of service XX is non-certified. A peer-to-peer discussion was unsuccessful despite calls to the doctor's office." Per a utilization review determination letter dated XX, the request for XX XX XX fusion with a date of service (DOS) of XX was denied by XX, XX with the following rationale: "Peer to peer was attempted but not established. Evidence-based guidelines state that prior to fusion, patients should attempt conservative management such as XX, XX, XX, XX modification, and anti-inflammatory medications. Surgery had been previously denied, and although a CT scan was provided for review, which did reveal an angulation XX, the documentation still did not address prior conservative management modalities as required by guidelines. In the absence of this documentation, the request is not supported. XX XX XX fusion, date of service XX is non-certified."

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

The ODG recommends fusion (XX) to treat nonunion of a XX, malunion of a XX or traumatic XX secondary to on-the-job injury when there has been a treatment failure of conservative care including XX and anti-inflammatory medications with persistent subjective pain is aggravated by activity and XX XX and relieved by XX injection, objective clinical findings of malalignment and/or decreased range of motion, and imaging findings confirming presence of loss of XX cartilage, XX XX, or non-union or malunion of the XX. The provided documentation reveals evidence of chronic XX XX pain and ongoing swelling with CT scan findings of a XX XX angulation XX related to an old healed XX XX XX. The physical examination documents a XX of the XX XX. However, there is no evidence that a diagnostic XX injection was performed. While there is evidence of immobilization with the use of a postoperative XX, there is no evidence of a treatment failure with anti-inflammatory medications. As such, the proposed XX XX XX fusion does not meet the ODG criteria. Recommendation is to uphold the previous denials.

Given the documentation available, the requested service(s) is considered not medically necessary and the decision is 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

ODG, XX: XX and XX