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DATE OF REVIEW: JANUARY 29, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of the proposed XX Total XX replacement (XX), XX Days of Inpatient Hospitalization and 1 licensed surgical assistant

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Orthopedic Surgery and is engaged in the full time practice of medicine.

REVIEW OUTCOME

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

XX Upheld (Agree)

☐ Overturned (Disagree)

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XX-year-old XX who was injured on XX, when XX. The claimant was diagnosed with XX XX disease of the XX XX. An XX of the XX XX without XX was performed on XX, XX, which revealed the following; XX tear extends to the XX and XX XX surface of the XX XX XX XX, subtle XX also extends to the superior XX surface of the XX XX XX XX, and minimal XX changes with the XX XX joint. An operative report dated XX, revealed that the claimant underwent XX of the XX XX, resection of tear of XX XX, resection of free edge XX of XX XX, XX of XX XX XX and XX of XX. An evaluation on XX, revealed that the claimant was having continued pain in the XX XX. The claimant reported that wearing a XX XX did help and was requesting a more definitive treatment. Current medications included XX.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:
The claimant has continued pain in the XX XX. According to the guidelines, a total XX replacement is recommended when there is evidence of significant loss of XX clear space identified on XX XX or during previous XX. There was no standing view XXof the XX XX performed and the operative report on XX, did reveal some changes of XX to the XX XX XX and XX XX XX but there was no evidence of significant loss of XX clear space or XX as required by

the guidelines. The guidelines also state there must be subjective complaints of stiffness and nighttime joint pain which was not documented. The guidelines would support the use of three days inpatient for a total XX replacement without complication, if deemed medically necessary. Therefore, medical necessity for a XX total XX replacement, three days of inpatient hospitalization, and a licensed surgical assistant has not been established and is not certified.

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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES