MEDRX

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DATE OF REVIEW: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
X

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)

X

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:

XX
X, Attorney
X, MD

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from:

X

Evaluation and treatment records, multiple dates-X Medical Center
MRI of X, X-American Dynamic Imaging
Designated Doctor Report, X

Workers' Comp Work Status Report, X
Required Medical Examination and report of such, X
Evaluation and treatment records, multiple dates-X Rehabilitation
Evaluation and treatment records, multiple dates-Dr. X

A copy of the ODG was not provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant was injured when X XX the X while X. X went to X with complaints of X pain. X was diagnosed with a X and X went to X at X. X had an MRI of the X on X that reported X tears in the X and the X along with X in the X and the X of the X. X had an MMI and impairment evaluation on X that found X not at MMI.
X had an additional X treatments of X. X was then evaluated by Dr. X, orthopedic surgeon. The doctor noted the diagnostic studies that showed significant X in the X. The doctor noted a XX XX of the X, range of motion 0-120, negative X and negative McMurrays testing. The doctor recommended an X. The doctor noted that X were not indicated as the X was a poorly controlled. X was taking X. The doctor did perform a X that provided relief for a few days.
A further designated doctor examination found X at MMI on X.

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

X, is not medically necessary. According to the ODG, the advantage of most surgery to treat X appears to be limited to short-term relief of pain and mechanical catching but does not prevent eventual X. Due to loss of X following acute X with or without additional removal of X, OA progression simply becomes inevitable. When feasible, primary surgical repair of X offers the best hope of X, but this procedure is associated with slower recovery and a relatively high (exceeding 20%) X, often requiring additional surgery. The benefit of surgery for X or in the presence of any OA drops off dramatically and may even be harmful, further accelerating OA progression. Ideal patients for X surgery are younger, with smaller or repairable X associated with mechanical symptoms and no associated OA. Due to the unsolved issue of OA progression for X with or without surgery, many previously accepted indications for X are now strongly questioned, especially for X, those with OA, and those with non-X. This claimant is X years old with typical XX-XX X conditions in the X. X is a X and has a history of X. X likely has X as X was treated with X. The MRI findings of significant X are augmented by the typical findings of X. This claimant not only does not meet criteria for surgery, the proposed procedure has the potential for disastrous results from XX poorly controlled X. There is no XX or XX that would necessitate surgery, and the X the X are not repairable. The requested procedure is not medically necessary and is noncertified due to not meeting requirements established by the ODG and established clinical guidelines used by experienced orthopedic 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)**