CASEREVIEW

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February 28, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
CT Scan of XX XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a Board Certified Orthopedic Surgeon with over 18 years of experience.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XX year old XX who was originally suffered injury to XX XX XX in a XX on XX and then again as a result of a work related injury. XX has received multiple XX XX XX, including XX from XX own XX and XX, as well as XX XX with multiple XX and XX. XX had to undergo additional XX and hardware placement during a surgery on XX. While on XX XX at work in XX XX, XX reported that XX experienced a 'XX' in XX XX and resulting pain. Imaging done at that time revealed that a XX in the XX had XX. The patient underwent surgery on XX to remove and replace the XX and XX. Post operatively, the XX was found to have XX and XX the XX XX joint which necessitated another surgery on XX. Since then, the claimant has been non-weight bearing in a XX and XX.

On XX, the claimant presented to XX, XX with a Pre-op diagnosis of XX of XX with XX XX XX XX XX XX. Planned procedure: Removal of hardware. XX XX XX, application and removal of XX XX. Application of XX.

On XX, Operative Report by XX, XX. Postoperative Diagnosis: 1. XX of the XX XX joint XX, XX XX XX. 2. Nonunion of the XX XX XX, XX XX XX. 3. Painful retained hardware, XX XX XX. Procedures Performed: 1. Open reduction with internal fixation of XX XX XX joint fracture XX. 2. Open reduction and internal fixation of XX XX XX XX fracture nonunion. 3. Removal of painful retained hardware. 4. Intraoperative fluoroscopic imaging. 5. Application of posterior XX.

On XX, the claimant presented to XX XX, XX s/p XX weeks XX XX XX XX XX non union and XX of the XX of the XX XX XX and removal of the painful hardware. XX presented in a XX, NWB in posterior XX and XX XX XX extremity, doing XX treatment and stating a XX stimulator. Plan: Advised to remain non-weight bearing/keep weight off XX XX extremity at all times utilizing XX-XX and XX for XX weeks.

On XX, the claimant presented to XX XX, XX as NWB in XX-XX and XX XX XX extremity. X-rays showed the bones were in acceptable anatomical alignment. The hardware demonstrated no evidence of loosening or failure. Moderate soft tissue XX was noted. Plan: Recommended XX injection. Also recommended weaning off the XX XX XX. Follow-up in XX-XX weeks with plan to perform a CT at that visit.

On XX, XX XX, XX performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. A clear rationale for the test is not known given that the x-ray findings did not reveal any abnormality.

On XX, XX, XX performed a UR. Rationale for Denial: Discussed case with XX. XX. XX states that XX did not intend to send request for XX injection for this particular issue and asks that the request be disregarded. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified.

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

The request for CT scan of the XX XX is denied.

This patient underwent revision XX XX surgery on XX. The surgery involved removal of hardware, XX of the XX XX joint malunion, and XX of the XX XX shaft nonunion. The XX office note indicated that the XX was healing in anatomic alignment on xray. A CT scan was recommended for the follow-up visit.

According to the records reviewed, there does not appear to be any evidence of failure of the XX surgery. There is no documentation of pain in the XX, by history or examination, that would point toward a problem at the surgical site. There is no radiographic evidence of bone malalignment or poor XX healing.

The recommended CT scan is not medically necessary at this time.

PER ODG:
XX

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)**