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DATE: 12/25/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

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

The reviewer is certified by The American Board of Orthopedic Surgery with over 11 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]:

XXXX.

XXXX: Office Clinic Notes, XXXX. Pt presents to clinic with a chief complaint of XXXX XX pain. Incident happened around XX XX. Pain from XX bone to XXXX XX. Pain of XX/10. States it hurts to move it or lift it. No XX or XX pain. No focalized tenderness of XX, AC joint or scapula. Limited ROM with abduction and elevation above XX. XX XX aspect of XX and XX arm. No axillary nerve deficit. Plan: Alternate ice/heat/Biofreeze. XX PRN. 2 View XX X-ray; negative. Diagnosis: XX of XX/XX of the XX XX of XXXX XX.

XXXX: Follow-Up with XXXX. XXXX X pain. Positive tenderness XX aspect of XXXX XX. Marked limitation of ROM of XXXX XX. Unable to abduct and raise XXXX arm above XX. No axillary nerve deficit. XXXX XX injury. R/O XX XX injury. Plan: MRI XX XX.

XXXX: New Patient Visit with XXXX. States pain and loss of motion since the injury, located XX at the XX as well as XX just XX to the XX. XXXX is unable to get an MRI as XXXX has old XX XX in the XXXX XX. XX has limited ROM and XX empty can test. Distally, XXXX is XX intact. XXXX does not have discomfort over the biceps tendon to palpation. X-Rays reveal some mild-to-moderate XX joint XX. XXXX XX is worrisome for XX XX XX. We will send for another MRI.

XXXX: CT XXXX XX Arthrogram. Findings: Extensive XX changes are noted about the XX joint with

XX XX, joint space XX and broadening of the XX joint surface. No evidence of full-thickness XX identified. Rotator cuff is intact. The XX XX exhibits a moderate XX XX with XX of the XX XX. The biceps tendon appears intact. XX XX changes are noted about the XX and XX joints (with associated moderate XX joint XX). No significant finding is appreciated, aside from presence of a XX XX XX in the XX XX muscle.

XXXX: Follow- Up Visit with XXXX. Pt is unable to work XX to XXXX symptoms. On exam, pt has positive XX and positive XX test. We are going to proceed with XX XX with possible biceps XX. This needs to get taken care of; pt is very symptomatic. We need to get XXXX back to work. XXXX. Assessment: Acute XX.

XXXX: UR by XXXX. Rationale: There is no documented evidence that the injured worker has undergone any course of conservative care including injection, rest, PT, or XX. Per ODG guidelines, surgical correction of XX XX is recommended in individuals with persistent symptoms following a XX-month failed trial of conservative care. Given the lack of documentation of such, there is no evidence to justify deviating from the standards. Non-Certified.

XXXX: UR by XXXX. Rationale. Within the associated medical file, there is documentation of the XXXX UR Determination identifying that an adverse determination was rendered due to a lack of documentation that the injured worker had undergone any course of conservative care, including injection, rest, PT, or XX. In addition, given documentation of subjective XXXX XX pain and objective findings of limited ROM, with positive XX and XX test; the XXXX CT XX of the XXXX XX identifying findings of a XX XX, with XX of the XX XX; and a diagnosis of XX XX, as well as activity limitations significant enough to justify surgery. However, despite conservative treatment including, medications, the previous adverse determination's concern for a lack of documentation that the injured worker has undergone additional course of conservative care, including injection, rest and PT has not been addressed. There was a discussion with XXXX, who identified the intention to provide an additional medical report documenting failure of conservative care treatment including injection and therapy. However, an additional medical report was not received by the time of the due date. Therefore, non-certified.

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

The previous adverse decisions are Upheld. This claimant is a XXXX who injured XXXX XX at work. XXXX has difficulty with active XX motion. XXXX has XX over XXXX biceps tendon. The recent CT XX of the XX demonstrated a moderate XX XX with XX of the XX XX. The XX tendon was intact. Extensive XX changes were identified in the XX joint with joint space XX. The treating physician has recommended XXXX XX XX XX and XX XX.

The Official Disability Guidelines (ODG) supports surgery for XX lesions following XX months of conservative care. Conservative treatment includes XX, injection and physical therapy. Biceps XX is recommended in patients over the XX of XXXX. XX XX is recommended in patients between the ages of XXXX. This claimant has no documentation of XX months of conservative care for XXXX XX injury. Therefore, the request for XXXX XX XX XX with XX XX is considered not medically necessary.

PER ODG….

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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)**