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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:

American Board of Orthopaedic Surgery

REVIEW OUTCOME:

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX.

On XXXX, magnetic resonance imaging (MRI) of the XX XX was performed at XXXX. The history was XX XX strain. The study revealed XX signal in the XX XX consistent with XX-XX XX XX. There was low grade XX joint XX. There was very XX joint XX. The XX (XX) joint revealed moderate XX. The XX process demonstrated a type XX XX XX configuration with mild XX XX. There was evidence of XX XX XX and subtle XX consistent with XX XX. There was XX XX particularly involving the XX XX component of the XX XX XX.

On XXXX evaluated the patient at XXXX. The XX XX pain was rated XX/10. The patient had attended XX therapy sessions, XX chiropractic treatments and taken XXXX. XXXX reported XX/10 XX pain with XX to the XX XX. XXXX had XX injection XX with XXXX which further relieved the pain, but it had been recurrent. XXXX recommended another XX injection and continued therapy to the XX, XX and XX. It was noted the patient attended XX additional therapy sessions to the XX. XXXX released the patient from the care for the XX. XX MRI

showed broad-based disc XX at XX-XX, XX-XX with mild XX XX only. The patient reported on XXXX, XXXX and started to XX XX pain to the XX side of the XX, XX XX and XX to the XX and XX XX. XXXX also had XX XX pain. XXXX was taking XXXX. History was notable for XX XX XX and XX XX arthroscopy in XXXX. XXXX had undergone XX XX XX injection in XXXX. On exam, the XX XX was tender over the XX XX and XX insertion. There was tenderness to the XX joint, XX and XX XX. The muscle strength was XX/5 in flexion, extension, external rotation, abduction and internal rotation. The range of motion (ROM) was flexion XX, abduction XX, internal rotation XX and external rotation XX degrees. Apley's test was XX. The XX XX had XX spasms to the XX XX, tender XX at XX-XX on the XX side and tenderness over the XX on the XX side. ROM was extension XX, XX rotation XX and XX rotation XX degrees. XX rotary compression test was XX on the XX side over the XX, XX and XX XX. Spasms were noted at the XX region and XX border of the XX on the XX. The diagnoses were XX of the XX XX, XX syndrome of the XX XX, biceps XX of the XX XX, strain of the XX, XX XX and XX of the XX disc without XX. The plan was to continue XXXX. The patient was referred for a second orthopedic opinion as XXXX had not improved enough. XXXX was referred to Pain Management for consultation. Chiropractic XX was recommended.

On XXXX, evaluated the patient for XX XX pain. The patient stated XXXX was initially seen by XXXX who prescribed XX medications. XXXX was able to return to XX duties until unfortunately, XXXX re-injured at work. XXXX had been having XX pain and XX XX pain. XXXX had a history of XX XX XX repair in XXXX. Most recently XXXX was seen by XXXX who administered an injection to the XX XX. Currently, the patient had pain in the XX rated XX/10 with constant XX down to the XX XX XX. It was accompanied with XX to the XX, XX and XX XX. XXXX also had constant XX XX pain rated XX/10. The pain increased when trying to do overhead movements or reach behind XXXX XX or XX. XXXX was XX XX XX on the XX side due to pain. XXXX was taking XXXX. On exam, XX XX had tenderness to palpation in the XX aspect. Active ROM was XX degrees abduction, XX degrees flexion, XX degrees internal rotation and XX degrees external rotation. XX were noted to the XX XX, XX and XX digits. The XX XX reflexes were decreased. Muscle strength was XX/5 to the XX` XX and XX as compared to the XX. Imaging studies were reviewed. X-rays of the XX XX showed no fractures, dislocations or subluxations. X-rays of the XX XX revealed type XX XX with XX riding XX XX which caused XX. No fractures, dislocations or subluxations were seen. XXXX proposed XX XX open XX since the patient had failed conservative treatment. The patient was to consult XXXX for XX issues.

On XXXX completed a Letter of Medical Necessity. XXXX stated since the patient had failed conservative treatment, and was a candidate for XX XX open XX. This condition was directly related to the patient's job-related accident and in accordance with ODG treatment guidelines.

On XXXX, a preauthorization request for XX XX open XX was documented.

On XXXX, utilization review was completed by XXXX., who denied the request for XX XX XX XX based on the following rationale: *"Official Disability Guidelines does not recommend XX XX surgery of the XX as an isolated procedure. There must be documented failure of conservative care (Physical therapy combined with home exercises, NSAIDs, corticosteroid injection, and taping are beneficial) for at least one year unless meets criteria for other associated surgical*

diagnoses and significant functional impairment persisting at least XX. AND pain with active arc motion between XX-XX degrees. AND positive impingement signs. AND temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS, conventional x-rays (AP, and true lateral or axillary view), AND MRI, ultrasound, or arthrogram shows positive evidence of impingement (XX, XX, type II or III acromion). In this case, this claimant appears to have XX XX XX. There is no failure of conservative care for one year as noted in the guidelines. Conservative care has included medications, rest, heat/ice, restriction, physical therapy (PT), XX injection x2 relieved pain, and light duty. However, guidelines do not recommend this type of surgery unless conservative care has failed for XX year. The injury was XX months prior. Therefore, proposed treatment consisting of XX XX Open XX is not medically necessary."

On XXXX recommended continuing the pain medications and PT. The patient was advised to follow up in XX weeks.

On XXXX documented letter of medical necessity for XX XX open XX. XXXX noted the rationale for denial and stated that it was true on the blue box on the ODG treatment guidelines it stated that at least XX XX of conservative treatment was recommended but on reading the articles and historical research they all state that this surgical procedure XX be considered after XX months of conservative treatment failure, such as the study by XXXX. Even under the recent research none of those studies mentioned conservative treatment for at least XX. They all mentioned conservative treatment failure from XX months. XXXX noted the patient had more than XX months of conservative treatment and unfortunately continued to be symptomatic.

On XXXX, a request for reconsideration was documented.

On XXXX., completed a reconsideration and upheld the denial for XX XX XX XX. Rationale: *"The medical record provided did not document specific physical examination findings consistent with XX, the specific amount of therapy or continued home exercise. The documentation was not in for at least XX XX as recommended by ODG prior to considering surgical treatment for XX syndrome and therefore the open XX XX XX was not medically necessary."*

On XXXX reevaluated the patient in a follow-up visit. The patient continued to have moderate intermittent XX XX pain, continued XX and XX XX pain. XXXX was seen by XXXX, who recommended some injections to be done XX. XXXX was taking XXXX. The examination of the XX XX revealed XX XX spasms XX XX. The XX XX had tenderness to palpation in the XX aspect. ROM was XX degrees XX, XX degrees flexion and XX degrees of XX and XX rotation. The XX XX had XX muscle XX XX. ROM was XX degrees extension and XX degrees flexion. XX was positive XX at XX degrees. The plan was to start XX and continue therapy. XXXX felt the patient was a candidate for XX XX open XX.

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

The opinions of the two preauthorization review physicians appear to be appropriately formulated based on ODG treatment guidelines (see below), *assuming* that the diagnosis of XX

XX is accurate (XX symptoms, XX symptoms, XX symptoms into the XX/XX/XX XX, as well as XX surgery that likely included a XX XX, are all factors that suggest "XX syndrome" is the wrong diagnosis). Surgery for XX syndrome does not appear to be medically necessary based on current ODG treatment criteria.

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**