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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Diplomate American Board of Orthopaedic Surgery

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

☒ Upheld (Agree)

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

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XXXX injuring XXXX XX XX, XX and XX.

On XXXX, evaluated the patient for XX XX and XX XX complaints. XXXX reported XX/10 pain that was described as XX. The pain did not radiate. The pain was constant and localized to the XX XX XX and the XX XX and XX area. The patient had XX pain and XX. The symptoms appeared suddenly and were ongoing for around XX weeks. The patient presented XX weight bearing with a XX and a XX XX. Examination of the XX XX showed XX causing XX in the XX XX. XX XX and XX exam showed XX over the XX. The range of motion (ROM) was deferred XX to XX. X-rays of the XX XX and XX XX. X-rays of the XX XX showed no evidence of fractures, dislocations, or arthritis. XX scan of the XX showed unstable three XX body and XX of the XX. The diagnoses were pain in XX XX, pain in XX XX and fracture of the XX. XXXX opined the claimant sustained an XX for which the treatment would be time and letting the fracture heal by itself. XXXX ordered XX of the XX XX.

On XXXX, XX XX of the XX XX performed at XX and interpreted by XXXX, showed full thickness, full-width XX of the XX XX to the level of the XX and with associated XX. There was mild XX and XX with medial dislocation of the XX tendon. There was thinning of the XX with XX present and with XX atrophy (XX XX) and XX XX.

On XXXX noted the patient had worsening XX XX symptoms since the XX. The XX XX had

improved. XXXX complained of XX, intermittent pain localized to the XX XX XX and aggravated by any XX of the XX. XXXX had XX XX XX and XX pain with improvement in XX. XXXX presented XX with a XX and a XX XX. The diagnoses were pain in the XX XX, pain in XX XX, fracture of the XX and complete XX of the XX XX. XXXX referred the patient to XXXX for XX and recommended monitoring for the XX XX complaints.

On XXXX., evaluated the patient for XX XX complaints. The claimant reported the XX pain in the XX aspect of the XX had steadily worsened and impacted XXXX ability to XX. Prior treatment included pain medication, XX (XX), activity modification, rest, home exercises and application of heat and ice. XXXX reviewed XX and diagnosed pain in XX XX, complete XX tear or XX of the XX XX, XX and XX of the XX XX. XXXX continued XXXX and recommended XX repair versus XX.

On XXXX, request for was submitted XX XX XX.

Per correspondence dated XXXX, XX notified the patient of non-certification of XX XX revision XX repair versus superior XX (XX). The rationale was as follows: *"There was a limited clinical indication for the requested treatment as the current symptoms were inadequate of significant pathology or objective findings. There were no clear documented measurable objective findings of failure from nonoperative treatment options. Documentation of trial and failure of all other lower levels of care was not identified in the records prior to considering surgical intervention."*

On XXXX, appeal to the determination was submitted on XXXX, for outpatient XX XX surgery. The patient had failed conservative treatment.

Per correspondence dated XXXX, the claimant was notified of the denial of the appeal for XX XX revision XX repair versus XX. The rationale was as follows: *"Per evidence-based guidelines, XX surgery is indicated in patients with pertinent subjective complaints and objective findings corroborated by imaging studies after the provision of conservative care. The patient presented with XX pain in the XX aspect of XXXX XX which been steadily XX and impacting XXXX ability to XX. An appeal request for XX XX revision XX repair versus XX versus XX XX was made; however, the specific objective clinical findings were still insufficient to fully necessitate the procedure. A more thorough assessment was not addressed in the recent records to note for pertinent findings. Objective response from prior conservative treatments received prior to the consideration of the surgery could not be identified in the records and validate adequate compliance, exhaustion, and failure from these treatments. Moreover, the guidelines indicated that XX XX reconstruction is not recommended for lack of higher quality studies and that this remains investigational due to XX controversy and lack of reproducible beneficial outcomes. Clarification is needed regarding the entirety of the request and how it might affect the patient's clinical outcomes. Clear exceptional factors could not be identified."*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
This claimant is XXXX injuring the XX XX, XX and XX. XXXX had treatment for a XX injury XX fracture. On XXXX, XXXX was evaluated at XXXX noting that there had been an unstable

XX mn fracture involving the XX XX body and a non-displaced XX of the XX. A XX of the XX XX was to be done. There was note in the records of a prior XX XXXX on the history for the XX that was completed on XXXX. Per XXXX, this MR XX demonstrated XX changes of the XX repair with a XX, full XX XX retracted to the level of the XX with only thin XX of even the XX. There was medial XX of the XX. There was XX. The XX and there was mild to moderate XX. There was no XX within the XX greater than the XX.

The patient was reassessed by XXXX, who noted the XX results. The previous XX had been done by XXXX. The patient was to be referred to XXXX for evaluation for further treatment. XXXX that the claimant had XX but weakness with activities. XXXX was having difficulty XX as well. There was reported positive XX well as XX sign. Discussion was held regarding options for care to include revision XX repair versus XX. The claimant's medication regimen included XXXX. XXXX was a XX. On this visit, XXXX prescribed XXXX as needed for pain and given XX XX.

Preauthorization was requested for the surgery and the request was denied as a medical necessity by XXXX who noted that there was incomplete documentation regarding a trial of and failure of all lower levels of care prior to considering this reconstructive surgery.

An appeal was done and completed on a peer basis by XXXX who documented that the proposed surgery to include the superior capsular reconstruction was not considered by ODG to be an established procedure. Thus, at the present time the superior capsular reconstruction was not considered as a recommendation for this type of problem.

No further records were available for review. The records do not provide adequate documentation of a trial of therapy or even a consideration for injection to assess the ability to reverse or abate the symptoms. There is no doubt that the claimant has a significant XX issue. However, the request as submitted is not approved as a medical necessity per ODG criteria. Thus, the previous adverse determinations are upheld.

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

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