AccuReview

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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:

This physician is Board certified in Orthopaedic Surgery with over XX years of experience.

REVIEW OUTCOME:

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

☒ Overturned (Disagree)

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: Encounters and Procedures dictated by XXXX. CC: XX shoulder pain. HPI: reported XX, XX, XX, XX/XX, XX/XX, XX down arm. ROS: Claimant reports XX/XX pain but reports no muscle aches, no muscle weakness. PE: Musculoskeletal: limited ROM in XX shoulder-unable to fully abduct, pain with forward flexion, pain with gripping. Assessment/Plan: Shoulder pain, XX.XX, pain in XX shoulder: arm sling, XXXX, MRI shoulder WO contrast. Patient instructed NSAIDs for pain, stay off joint or limit use of, RTC in anything changes or worsens.

XXXX: MR-XX Shoulder, without contrast dictated by XXXX. Impression: No evidence

of rotator cuff tear, moderate supraspinatus and infraspinatus tendinosis without rotator cuff tear, moderate XX XX, mild XX outlet stenosis secondary to XX XX tilt, moderate XX XX with associated XX XX XX, chronic XX tear of the XX with moderate degree of XX XX, XX joint XX is noted, no acute XX XX is noted.

XXXX: Office Visit dictated by XXXX. CC: XX shoulder pain: dull and aching, yet moderate, constant and unchanged. Pain worsened with increased activity and now reported constant pain and limited ROM. XXXX gave minimal relief. PE: XX shoulder: rotator cuff weakness 4/5, positive XX sign, positive XX sign and positive XX test; tenderness mild and entire shoulder; slightly decreased forward XX XX, XX XX, XX rotation and XX rotation with tone mildly decreased and 4+/5 sensation; no laxity and typical for rotator cuff disease. DX: XX.XX-XX pain in XX shoulder, XX.XX-XX.XX superior XX XX lesion on the XX shoulder, initial encounter, XX.XX-XX.XX Other XX XX disorders, XX shoulder, XX.XX-XX.XX Incomplete rotator cuff tear or rupture of XX shoulder, not specified as traumatic, XX.XX-XX.XX Bursitis of the XX shoulder, XX-XX-XX-XX XX syndrome of XX shoulder. Plan: Will place claimant on modified light activity at work and will reassess XXXX progress in 6 weeks to see if conservative treatment helped. XXXX received XX injection today and prescribed anti-inflammatory medication.

XXXX: Office Visit dictated by XXXX. CC: XX shoulder pain unchanged. PE: unchanged. Plan: The claimant arrives for reexamination of XX shoulder and has finished outpatient PT, but while XXXX shoulder has gotten stronger, XXXX is still complaining of constant pain in XXXX shoulder. XXXX wanted to discuss surgery. Because XXXX has failed conservative treatment and with continued significant mechanical problems of the shoulder and would like to return to an active lifestyle, recommend surgical intervention: diagnostic XX, XX repair versus XX XX XX tenodesis, extensive XX, XX decompression, and any indicated procedures.

XXXX: UR performed by XXXX. Reason for denial: There is no objective documentation of lower levels of care with NSAIDs as required by the guidelines or mention of a XX. There is no diagnostic imaging reporting an acute XX XX or XX XX XX tear. The request is non-certified.

XXXX: Office Visit dictated by XXXX. CC: XX shoulder pain. PE: XX shoulder: positive XX XX and XX XX test; tenderness on the XX XX of the XX XX, mild entire shoulder tenderness, forward XX XX passive, XX active, internal rotation and external rotation; tone mildly decreased. DX: unchanged. Plan: XX XX denies surgery and XXXX shoulder still hurts as much as it did at XXXX previous visit, and XXXX symptoms are still consistent with a XX tear. Other than surgery there is no other plan than surgery when it is approved.

XXXX: UR performed by XXXX. Reason for denial: The claimant is a XXXX who was injured on XXXX while XXXX. The developed pain in the XX shoulder, claimant was diagnosed with rotator cuff and XX tears with XX. Prior treatment included PT and shoulder injection on XXXX. The MRI on XXXX XX/XX/XX of the XX shoulder found no evidence of a rotator cuff or XX XX. There was evidence of XX XX disease and XX of the rotator cuff or XX tear. On XXXX clinical report noted ongoing XX shoulder pain with XX XX and XX XX with tenderness to XX over mild loss of ROM. This is an appeal of previous denial which noted lack of documentation regarding failure of non-operative measures and limited findings on imaging regarding pathology at the XX. The records submitted do not address the prior concerns. The claimant's imaging found no evidence of any XX or rotator cuff tears that would support proceeding with a XX repair. There was also limited documentation regarding prior non-operative measures. Given these issues which do not meet guideline recommendations, this reviewer cannot recommend certification for the request.

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

The request for outpatient XX shoulder XX with XX repair versus XX versus XX, extensive XX, and XX XX is approved. This claimant sustained a work injury to XXXX XX shoulder. XXXX has been treated with physical therapy, NSAIDs, and XX injection. On examination XXXX has a positive XX XX (XX) and positive XX XX (pathology XX/XX XX). The XXXX MRI demonstrated moderate rotator cuff XX, without tear. XXXX also had a chronic XX tear of the XX with moderate degree of XX XX. XXXX is unable to return to full duty work status due to XXXX functional limitations. The treating physician has recommended XX surgery to address the rotator cuff XX and XX tear. XX decompression is the standard procedure for patients with rotator cuff XX with XX, who have failed conservative care. The Official Disability Guidelines (ODG) recommends XX XX for XX tears associated with XX XX in patients between the ages of XX and XX years. The ODG supports shoulder XX with XX in patients with XX of the shoulder, under the age of XX years. This claimant meets surgical criteria. Even though XXXX has moderate shoulder arthritis on MRI, XXXX is a candidate for XX of the shoulder, based on XXXX age. At the time of surgery, the XX XX tear identified on MRI may require XX versus repair. XX XX may be necessary if the XX XX is torn. No further improvement in this claimant's condition without surgical intervention. The recommended procedure is medically necessary. Therefore, after reviewing the medical records and documentation provided, the request for Outpatient XX Shoulder XX with XX Repair vs XX, XX vs. Repair, XX XX is overturned and approved.

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)**