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DATE: 11/22/18

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 10 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]:

Claimant is a XXXX, when XXXX with a complaint of XX XX pain.

XXXX: MRI XX XX. Impression- 1. XX-thickness, near XX XX XX of the XX and XX with slight differential retraction of the XX and XX fibers. Mild muscular XX is noted with mild XX XX and grade XX XX infiltration, suggesting XX XX XX. 2. Additional XX and XX-XX XX type tearing of the XX with muscular XX involving the XX XX muscle XX, which is also suggestive of acute XX XX type injury. 3. Mild XX XX joint XX change with slight XX XX XX and early XX-XX changes. 4. XX and XX type XX of the XX XX with XX XX into the XX XX.

XXXX: Progress Note by XXXX. Pt here for pre-op visit. Still having XX all the time. XXXX. Physical Exam- Palpation Tenderness (R)- moderate, over the long head of the biceps , over the XX, and over the upper XX. Strength and Tone (XX)- Biceps- XX/5. XX-XX/5. Infraspinatus- XX/5. Deltoid- XX/5, Triceps- XX/5. Weakness- on XX and XX XX. Testing limited due to

XX and due to pain. ROJM: Right: Internal Rotation: XX: Note XX. External Rotation-XX-XX^0. XX: Internal Rotation: XX Note XX. External Rotation- XX- XX^0. Flexion- XX-XX^0. Glenohumeral Abduction- XX- XX^0. Instability- XX- Popping on movement of XX. Negative XX instability, apprehension test, circumduction test, posterior apprehension test, posterior instability, sulcus sign. XX- XX instability. Impingement Test XX, XX. Functional Testing- XX- empty can test XX, infraspinatus test XX and supraspinatus test XX. Pt was fitted and sent home with XX XX XX.

XXXX: Progress Note by XXXX. Persisting XX XX pain. Mild to moderate, XX, XX. Pain is aggravated by any movement, overhead activity and lifting. There are no relieving factors. No previous diagnostic tests. No previous physical therapy or evaluations. Decreased ROM, joint pain and joint XX. I have discussed conservative versus surgical treatment options with the patient. I feel the patient would be a good candidate for XX XX XX with XX, XX XX Excision, Extensive XX, XX Release, XX, XX XX Removal, XX XX Repair, XX Repair, and XX XX. The patient has failed conservative treatment measures, including; physical therapy, injections, and medications. I feel this is medically necessary and important in treating the patient's condition.

XXXX: Progress Note by XXXX. Persistent pain for XX months. The course has been without change. Mild to moderate. XX XX. Aggravated by any movement, work duties, overhead activity and lifting. Pain is all the time and XX pains when lifting. XXXX. Plan- Physical Therapy, XXXX. A complete diagnostic US was performed of the XX. The XX XX was visualized using real time visualization. The XX has a XX thickness XX involving XX% of the XX thickness along the XX leading edge with no evidence of XX. The XX, XX, and XX minor are intact. The XX XX has XX surrounding it consistent with XX. The XX structures are XX. Physical Exam- Palpation Tenderness (R)- XX, over the long head of the biceps , over the XX, and over the XX trapezius. Strength and Tone (R)- Biceps- XX/5. Supraspinatus-XX/5. Infraspinatus- XX/5. Deltoid- XX/5, Triceps- XX/5. Weakness- on abduction and rotator cuff. Testing limited due to guarding and due to pain. ROJM: Right: Internal Rotation: AROM: Note XX. External Rotation-XX- XX^0. XX: Internal Rotation: XX Note XX. External Rotation-XX- XX^0. Flexion- XX-XX^0. Glenohumeral Abduction- XX- XX^0. Instability- XX- Popping on movement of XX. Negative XX instability, apprehension test, circumduction test, XX apprehension test, XX instability, XX sign. XX- anterior instability. Impingement Test XX, XX. Functional Testing- XX- empty can test XX, infraspinatus test XX and supraspinatus test XX.

XXXX: Physical Therapy Progress Summary. Pt is still having severe pain and weakness with XX shoulder over the past few weeks XX/10 pain on average. XX PT visit. Able to passively stretch the XX more into flexion and rotation but strength not improved. Pt is working light duty. XX pain and limited with reaching ADL/lifting ADL XX. Unable to do much of any reaching with XX elbow away from side. Mod to severe limit with XX and XX XX XX, doing most things with XX. XX compliant. Objective Measurements- XX: XX shoulder XX flex XX, IR XX, ER XX pain at EROM flex>ER/IR. Strength: XX/XX flex/XX, XX/5 ER. XX+/5 IR. Demo pain with XX>flex, ER>IR. Mild rounded XX protracted XX and guarding XX due to pain. Movement Tests: Deme extremely XX and painful XX XX XX. Much better with closed stretches vs. open chain and well with light R/C and stab ex. Signs and symptoms are consistent

with XX, most likely due to XX R/C XX, which has gained some probability over first few weeks but not made much progress with strength or pain. Pt appears that XXXX will need R/C repair. PT XX wk for XX wks.

XXXX: Progress Note with XXXX. XX pain has been gradually worsening. Pain is moderate, dull aching. Located in the XX shoulder. No relieving factors. Painful ROM, difficulty with overhead activities, difficulty with pushing, pulling, and lifting. Previous diagnostic test include plain radiographs. Previous meds include anti-inflammatory meds and XX injections, intra-articular. Having XX pain and XX ROM. Difficulty raising XXXX XX arm. XXXX. . Strength and Tone (R)- Pectoralis major- XX/5. Biceps- XX/5. Supraspinatus-XX/5. Infraspinatus- XX/5. Deltoid- XX/5, Subscapularis- XX/5. Instability- XX- XX on movement of XX. Negative XX instability, apprehension test, circumduction test, posterior apprehension test, posterior instability, sulcus sign. Impingement Test XX, XX. Functional Testing- XX- empty can test XX, infraspinatus test XX and supraspinatus test XX, Neer AC test XX, Neer impingement test XX. Rt AC crossover adduction test XX, biceps load test XX, Jobe test XX, Obrien's Test, XX prehension test, Speeds test and Yergason's test , XX XX. Pt continues to have activity limiting XX pain which has not improved with conservative treatment including medications, PT, XX injection. At this point, I feel the patient will not improve without surgical intervention.

XXXX. Rationale- I spoke with XXXX and designee, who stated the other injections were XX. There has not been a specific XX joint injection. The claimant has XX XX XX that is going to be addressed in surgery. The plan is to address other issues while in surgery, as well. The claimant has biceps XX, given the swelling found on US, that is consistent with XX, it was stated. The claimant does not fully meet the criteria for all the request per ODG. Not medically necessary.

XXXX. Rationale- The ODG supports a R/C repair for individuals with XX pain and inability to XX the arm. Although XXXX recent progress note dated XXXX does not reveal ROM measurements, a previous noted dated XXXX reveal ROM of active flexion and abduction to XX^0. This does not indicate XX to XX the arm. Additionally, regarding the XX decompression, the guidelines only support this associated procedure for individuals who have XX syndromes and temporary relief of XX steroid injection. Although a steroid injection was provided in the XX space, the efficacy of this injection was not indicated. Regarding the partial XX, guidelines indicate there should be tenderness at the XX joint or temporary relief with a steroid injection in this region. Progress note dated XXXX states there is no tenderness at the XX and no previous steroid injection has been performed at the AC joint. Without an indication for the XX surgeries, the request is not medically necessary.

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

The previous adverse decision is Upheld. This patient is a XXXX. The XXXX MRI of the XX identified full-thickness XX of the XX and XX. XX and low grade XX was noted in the XX. Mild XX (AC) arthritis was reported. A degenerative XX tear was also identified. The XXXX ultrasound identified a XX% partial XX of the XX supraspinatus, without retraction. Fluid in the

XX XX was consistent with XX.

The patient has XX a course of physical therapy, medication, and XX cortisone injection. The treating physician has recommended surgical intervention.

The Official Disability Guidelines (ODG) supports XX XX excision in patients with severe XX of the AC joint. Surgical candidates have tenderness over the XX joint or have had some pain relief following a XX injection to the XX joint.

The ODG supports XX XX for the treatment of XX XX in patients XX the age of XX years. In patients XX the age of XX years, XX XX is recommended.

This patient does not satisfy ODG criteria for XX XX XX or XX XX. There are no unusual circumstances that would support XX XX in this patient, who is XX XX years old age. It is not clear why this patient requires a XX repair. Therefore, the request for XX XX Arthroscopy with XX, XX XX Excision, Extensive XX, Capsular Release, XX, XX Body Removal, XX XX Repair, XX Repair, and Biceps 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)**