AccuReview

An Independent Review Organization
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November 5, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX XX, XX, 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 15 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: XX w/o Contrast XX dictated by XXXX. Impression: 1. No significant fluid to outline the XX XX however increased XX signal in the XX XX is concerning XX. Post XX MRI would provide better detail if clinically warranted. 2. XX and XX tearing at the XX surface of the XX XX. This may be secondary to arthritic change from the XX. 3. XX at the XX region.

XXXX: Office Note dictated by XXXX. CC: XX XX. HPI: XXXX. Pain has worsened since the initial injury and wakes XXXX up at night. Reported limited ROM with pain throughout movement of XX with only alleviating factor is rest. Prescribed medications: XXXX. PE: XX: XX: limited ROM due to pain. Approximately XX degrees of forward elevation and abduction with XX pain at limits. Limited ER with pain, unable to tolerate XX testing. XX intact. Pain in XX XX. Impression: Will submit for XX including XX with XX w/ XX. Claimant unfortunately has not been sent to therapy to this point resulting in a XX XX. PT RX provided. XXXX will require therapy after XX. XX weeks postop.

XXXX: Request for Services dictated by XXXX: XX XX pain. Duration/Frequency: XX per week for XX weeks, XX therapy ROM exercise, strengthening exercise, and HEP.

XXXX: XX XX X-Ray dictated by XXXX. Findings: The XX XX is smooth and regular. No

fractures or dislocation. XX AC joint intact. No subluxation.

XXXX: XX XX Therapy Evaluation dictated by XXXX: XX XX pain, pain XX OP. XX XXXX. Claimant experienced XX pain with evaluation. Recommend XX treatments.

XXXX: Authorization Request dictated by XXXX. XX. Requesting XX totaling XX-XX sessions.

XXXX: Office Note dictated by XXXX. CC: PT for a FU for XXXX XX XX pain, XX/10 on pain. XXXX has completed XX sessions of PT as approved by XX. XXXX continues to have severe aching XX XX pain that is worse with movement of the XX and when XXXX lies on the XX at XX. Pain wakes XXXX from XX at night. XXXX continues to have XX limited ROM that makes it difficult to perform daily and work activities. XXXX is unable to take XX due to XX. PE: XX: RUE: limited ROM due to pain, approximately XX degrees of forward elevation and abduction with active and passive ROM; pain at limits. Limited ER with pain, lacking XX degrees compared to XX, unable to tolerate XX testing. Pain in XX. Impression and Plan: Claimant has XX XX pain due to XXXX. XXXX has failed nonoperative treatment course including activity modification and multiple sessions of PT; XXXX has XX XX and decreased ROM and pain that limit daily and work activities. Treatment options discussed, recommend surgical treatment at this point to which XXXX is amenable. We will submit for surgery including MUA, XX with XX XX and possible XX, continue XXXX, and will call for XX date, FU XX weeks.

XXXX: UR performed by XXXX. Reason for denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, surgery is indicated in cases with pertinent subjective complaints and objective findings corroborated by imaging and after provision of conservative treatment. In this case, the claimant had persistent XX XX pain with decreased ROM. The MRI dated XXXX showed no signification fluid to outline the XX XX however increased XX signal in the XX XX was XX and XX. There was a prior adverse determination dated XXXX whereby the request for XX XX XX, MUA, XX was non-certified. The reviewer noted that the proposed treatment is not consistent with our clinical review criteria; however, no letter was attached for review. It was mentioned on XXXX, the claimant completed XX sessions of PT; however, there were no actual records submitted for review. In addition, there was limited documentation of trial and failure of conservative treatments to warrant the current request. There were no exceptional factors noted.

XXXX: UR performed by XXXX. Reason for denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. Per evidence-based guidelines, XX surgery is reserved for cases failing conservative therapy for at least XX months with evidence of pertinent subjective complaints and objective findings, corroborated by imaging studies that would be suggestive of deficits and functional limitations on the XX. In this case, the claimant complained of XX XX pain rated as XX/10. MRI dated XXXX revealed that there was no significant fluid to outline the XX XX however increased XX signal in the XX XX is concerning for a XX XX. Although the claimant had completed XX approved sessions of PT; however, there was no comparative

quantifiable clinical objective evidence of improvement from the PT sessions to validate the efficacy or failure of this conservative treatment. Furthermore, there were no exceptional factors noted to warrant the need for the requested surgery.

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

The previous adverse determinations are upheld and agreed upon, as the request for XX XX XX, XX under anesthesia, XX is denied. This claimant has XX XX pain and limited XX of the XX. XXXX has completed XX sessions of XX therapy. XXXX XX MRI demonstrates a partial XX. The treating physician has recommended XX under anesthesia, XX XX with XX XX, and possible XX with XX XX. The Official Disability Guidelines (ODG) recommends XX months of conservative treatment for XX XX prior to surgical consideration. This includes XX therapy, XX. This criterion has not been met as the claimant will require more than XX sessions of XX therapy, prior to surgical consideration for XX, as well as require a XX injection to the XX. Therefore, medical necessity has not been met and the claimant is not a surgical candidate as this time; furthermore, the request for XX XX XX is denied.

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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)**