Applied Independent Review

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Notice of Independent Review Decision

Amended Date: **03/26/2019**

Case Number: **XX** ***Date of Notice:*** 03/22/2019

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

XX XX arthroscopy with evaluation of the XX XX, XX decompression, XX XX XX and XX lesion repair

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

- ☐ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☑ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XX. XX XX is a XX-year-old XX who was injured on XX. XX reported that XX was XX with a XX on a XX at XX and XX to have XX and XX XX dislocated XX XX. XX stated XX did quite a bit of XX and had no real specific injury, but was hurting quite a bit from the XX that XX had been doing the prior XX months. At that time, XX was diagnosed with XX XX XX joint inflammation and XX XX XX from XX / working; and XX XX chronic impingement, likely from the inferior XX XX caused from the inflammation in the XX joint. The ongoing diagnoses are sprain of XX XX joint, XX (XX.XX); XX syndrome of XX XX (XX.XX); and pain in XX XX (XX.XX).

XX. XX visited XX on XX for a follow-up of XX XX XX injury. XX was XX-and-a-XX months post injury. XX stated XX XX had denied XX surgery. XX reported XX had completed XX XX therapy and had gone a little over XX weeks with no change in XX symptoms. XX continued to complain of pain with XX activities, XX-XX motions, etc. Examination of the XX XX noted continued prominence superiorly and anteriorly over XX XX joint. XX was tender to palpation there. XX had a moderately-positive XX impingement sign. Range of motion was pretty decent and very similar to the other side, but it hurt with internal rotation and forward flexion. Forward flexion was 165 degrees, external rotation 40 degrees, and internal rotation to XX. There was no real XX with range of motion. XX was XX intact distally, with no skin lesions or adenopathy. The assessment was XX XX sprain of XX joint with resultant XX XX XX and impingement that had failed conservative treatment; and possible XX tear, which was unable to be visualized on the MRI because of the poor quality. XX documented that because XX. XX had significant continued problems with the XX and its function with a substantial amount of pain, XX would recommend surgical intervention. Because of the physical change to the bone of the XX, with its XX changes and XX in that XX XX and XX joint that caused inflammation and a resultant impingement inferiorly to that, that could be seen on the MRI, XX did not think this was going to do well conservatively, and ordered XX XX arthroscopy, evaluation of the XX XX particularly, XX decompression, and XX XX XX.

An MRI of the XX XX dated XX demonstrated reactive XX XX XX noted in the articular surface of the XX XX. There was XX XX and trace joint effusion in the XX joint. It was noted that the findings could represent XX XX XX.

Treatment to date included medications (XX cream that helped quite a bit), XX XX XX injection (temporary relief), nine visits of physical therapy (no change in pain), and modified duty.

Per a utilization review letter dated XX, XX, recommended that the prospective request for 1 XX XX arthroscopy with decompression, XX XX XX, debridement, and XX / XX lesion repair between XX and XX be noncertified. Rationale: "According to the cited guidelines, criteria for XX decompression for XX impingement syndrome (80% improve without surgery): significant functional impairment persisting at least XX year, and pain with active arc motion between 90-130 degrees. Imaging should show positive evidence of impingement (XX XX, XX XX XX, type II or III XX). Surgery is not indicated. The claimant's range of motion is improving over time it appears, and the claimant is stating that their pain is greatly reduced with medications. Furthermore, the claimant's MRI fails to show anything indicative of impingement per the progress reports. Based on the cited guidelines and information provided, the request for 1 XX XX arthroscopy with decompression, XX XX XX, debridement and XX / XX lesion repair is non-certified."

Per a utilization review determination letter dated XX, by XX, the request for 1 XX XX arthroscopy with evaluation of the XX XX, XX decompression, XX XX XX and XX lesion repair between XX and XX was non-certified. Rationale: "The Official Disability Guidelines recommend surgery for impingement as an option for the treatment of impingement but is not recommended as an isolated procedure. There must have been at least XX year of conservative care with significant functional limitation, nighttime pain, and painful arc. There should be positive diagnostic injections and corroborative imaging findings. XX XX resection is recommended for evidence of post-traumatic XX of the XX (XX) joint. There must be at least XX weeks of conservative care with pain at the XX joint or a history of prior separation. There should be a positive diagnostic steroid injection. Imaging should demonstrate posttraumatic changes of the XX joint, severe XX joint disease or complete separation of the XX joint. The Official Disability Guidelines recommends direct repair surgery for Type II lesions and Type IV XX lesions involving more than 50% of the XX tendon. There must have been at least XX months of conservative care consisting of NSAIDS, injection, XX therapy, and significant activity limitations. The patient's history, physical examination and imaging must support a XX tear. Official Disability Guidelines only supports arthroscopy for a XX decompression if there are impingement signs on examination and imaging studies as well as temporary relief demonstrated with a XX injection. In this case, no injection has been provided for this claimant at the XX space. Similarly, regarding a XX XX XX, no steroid injection has been provided at the XX joint. Furthermore, the XX MRI does not reveal any definitive evidence of a XX tear or physical examination findings to indicate that one might be present. Considering the absence of previous conservative treatment for at least XX year and objective findings, this request is not in line with the guideline criteria. Therefore, 1 XX XX arthroscopy with evaluation of the XX XX, XX decompression, XX XX excision and XX lesion repair is non-certified."

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The ODG recommends XX procedure (XX XX XX) when there is pain at the XX joint, objective tenderness over the XX joint and/or pain relief obtained with an injection of the XX joint, posttraumatic changes or degenerative joint disease of the XX joint, and a failure of at least XX weeks of conservative care. The ODG does not recommend surgery for XX syndrome is an isolated procedure and recommends at least XX year of conservative treatment unless earlier surgical criteria are met for other associated diagnoses. The ODG recommends surgery for XX lesions following a failure of XX months of conservative treatment including NSAIDs, injection, and XX therapy. The provided documentation reveals evidence of persistent XX XX pain approximate XX months out from injury despite treatment with activity modification, approximate XX weeks of XX therapy, and XX joint injection, and medications. It is documented the injection provided temporary relief. There are physical examinations findings of prominence and tenderness of the XX joint and positive impingement testing. There are MRI findings of posttraumatic changes of the XX joint including reactive XX XX XX in the articular surface of the XX XX, XX XX, joint effusion in the XX joint, and XX XX XX. As there is evidence of a failure of XX weeks of conservative treatment, reproducible pain at the XX joint, temporary relief with an injection of the XX joint, and imaging findings of post dramatic changes of the XX joint, the XX XX XX is supported. While not all criteria are met for XX decompression, when noting there is XX of the XX joint that could cause impingement with positive impingement testing on physical examination, it will be prudent to address the symptomatic impingement of the time the supported XX XX XX as failure to do so could lead to persistent pain and functional limitation with potential need for additional surgery in the future.

As there is no evidence of a XX tear on MRI, the proposed XX lesion repair is not supported. Based on the provided documentation, the XX XX XX with XX decompression and XX XX XX is medically necessary and overturned, but XX lesion repair is not medically necessary and upheld.

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

The XX XX arthroscopy with XX decompression and XX XX XX is medically necessary and overturned, but XX lesion repair is not medically necessary and therefore upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)