

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/22/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right shoulder arthroscopy/29805 with Debridement/29823

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., board certified in Orthopedic Surgery

REVIEW OUTCOME:

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 2/17/09, 4/7/09
Primary Rehab Progress Notes, 11/29/06-4/10/07
Peer Review Reports, 2/13/09, 4/3/09
Orthopedic Clinics, 10/17/08, 2/6/09, 2/20/09
MRI Shoulder, Right, 1/25/08
Right Shoulder Arthrogram and CT Arthrogram, 11/6/07
H&P, 11/27/06

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a remote history of a labral repair and extensive physical therapy several years ago. On review of the current medical records, we do not see any indication of conservative care such as physical therapy, appropriate medications, activity modifications, and/or injection of steroids. Current request is for a diagnostic arthroscopy with debridement.

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

The previous reviewer has indicated that due to the absence of conservative care, in particular physical therapy, nonsteroidal anti-inflammatory medication, and infiltration of cortisone, this patient has not met the ODG Guideline criteria for a diagnostic arthroscopy in this particular circumstance. The medical records do not contain any notation from the treating surgeon as to why the recommended conservative nonoperative modalities have not been implemented and why the statutorily mandated ODG Guidelines should be set aside in this particular individual's case. It is for this reason that the previous adverse determination could not be overturned. The reviewer finds that medical necessity does not exist for Right shoulder arthroscopy/29805 with Debridement/29823.

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

ACOEM-AMERICA 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)