

Core 400 LLC

An Independent Review Organization
240 Commercial Street, Suite D
Nevada City, CA 95959
Phone: (530) 554-4970
Fax: (530) 687-8368
Email: manager@core400.com

DATE OF REVIEW:

May/28/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

ASC Left Shoulder Scope w/pos RCR/and SAD, 29827 29826

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

Determination Letters, 4/3/09, 4/28/09

Dr, MD, 4/16/09, 3/27/09, 1/29/09, 2/23/09, 12/10/08, 12/22/08, 11/13/08, 10/10/08, 8/27/08, 9/12/08, 6/30/08, 7/10/08

MRI Shoulder with Contrast, 4/14/09

MRI of the Right Shoulder, 12/16/08

MRI Left Shoulder w/o contrast, 7/7/08

Operative Report, 9/2/08

PATIENT CLINICAL HISTORY SUMMARY

This is a male who injured his shoulder on xx-xx-xx. He has had physical therapy, anti-inflammatory medications and diagnostic injections into the left shoulder, which gave him about a week's relief. He has had an MRI that documents intrasubstance tearing and tendinopathy. He has clinical findings compatible with subacromial impingement. He has had a previous left shoulder arthroscopy. The current request is for repeat left shoulder arthroscopy, acromioplasty and possible rotator cuff repair. It is stated that the patient has had an MRA of the shoulder which documented the rotator cuff pathology and tendinosis involving both the supraspinatus and intrasubstance tear of the supraspinatus.

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

Based upon the ODG Official Disability and Treatment Guidelines, this patient has satisfied the time requirement, the conservative care requirement, the injection requirement, and the objective diagnostic findings compatible with the physical findings criteria. It is for this reason

that the previous adverse determination has been overturned. The request meets the guidelines. The reviewer finds that medical necessity exists for ASC Left Shoulder Scope w/pos RCR/and SAD, 29827 29826.

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)