

Prime 400 LLC

An Independent Review Organization
240 Commercial Street, Suite D
Nevada City, CA 95959
Phone: (530) 554-4970
Fax: (530) 687-9015
Email: manager@prime400.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/29/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Rt shoulder scope, AC injection resection, subacromial decompression, possible RTC repair, possible labral repair

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

M.D., Board Certified Orthopedic Surgeon

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

Denial Letters/Peer Reviews, 10/1/10, 10/12/10

Orthopaedics, 2/12/09-10/13/10

Medical Center 9/24/10

9/30/10

Official Disability Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who apparently was injured when he had another individual fall on top of him. He is xx . He has had some physical therapy for his shoulder. He has not had a subacromial injection that we were able to determine from the medical records. He has an MRI scan that reports that he has peritendinitis and grossly intact rotator cuff, some acromioclavicular arthropathy with medial and lateral stenosis, and subtle irregularities suspicious for labral tear, though this was not clearly identified. The MRI scan does not report that the patient has any impingement. The patient also underwent an MRI scan with arthrographic injection of contrast, which showed no rotator cuff tear, no labral tear, and there was no evidence of any impingement on this study from 09/24/10. Current request is for Rt shoulder scope, AC injection resection, subacromial decompression, possible RTC repair, possible labral repair.

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

Based on the MRI scan which does not confirm the presence of impingement or rotator cuff tear or labral repair, in fact, is clear to the contrary, and the failure of this patient to have had a subacromial injection of cortisone as at least a diagnostic if not therapeutic modality, this patient does not meet the Official Disability Guidelines and Treatment Guidelines for the shoulder surgery that is being requested. The previous adverse determination cannot be overturned. The requesting surgeon has not explained why, in this particular case, the ODG Guidelines should not be followed. The reviewer finds that medical necessity does not exist at this time for Rt shoulder scope, AC injection resection, subacromial decompression, possible RTC repair, possible labral repair.

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)