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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/23/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

ASC Lt shoulder arthroscopy w/subacromial decompression possible RCR and 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

Care, 12/22/09, 12/28/09, 01/26/10

Office notes, Dr., 1/6/10, 01/25/10

Left shoulder MRI, 01/12/10

MRI cervical spine, 1/12/10

Utilization Review, Dr., 02/02/10

Utilization Review, Dr., 02/22/10

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates, Shoulder Chapter, Surgery, acromioplasty and rotator cuff repair

PATIENT CLINICAL HISTORY SUMMARY

This was injured when a horse pinned her to a wall on xx/xx/xx. She has complaints of left sided neck pain and left shoulder pain. Initial care was provided at an Care Center; and then she was referred to an orthopedist for evaluation and treatment. Dr. ordered a left shoulder MRI which documented findings likely representative of tendinopathy or a partial tear in the area of the supraspinatus tendon, some suggestion of bursitis, at the adjacent glenoid labrum, thought to be degenerative although a chronic labral tear was not excluded, additionally there was moderate acromioclavicular joint arthrosis present. An MRI of the cervical spine documented mild neural foraminal stenosis on the left at C4-5 and moderate to severe neural foraminal stenosis at C5-6. Dr. has documented examination findings of tenderness in the left cervical muscles and left trapezius, swelling of the left trapezius; left shoulder with anterior tenderness, swelling in the anterior trapezius region, abduction with

internal rotation causes pain, forward flexion with internal rotation causes pain. Dr. has documented a diagnosis of a left shoulder partial thickness rotator cuff tear, and impingement syndrome. The physician has recommended proceeding with an arthroscopy for an anterior acromioplasty and rotator cuff repair. There is an absence of documented conservative care such as physical therapy. Medications have been prescribed which include Darvocet and Vicodin, Toradol, Flexeril, antidepressants, and sleep aids.

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

Review of the records provided supports that the claimant is a , with the diagnosis of left shoulder pain, a questionable rib injury, and cervicgia. MRI done on 01/12/10 showed degenerative changes, tendinopathy, and question of a partial tear. An MRI of the cervical spine showed multilevel degenerative changes.

Dr. recommended arthroscopy with an acromioplasty and rotator cuff repair. It was reviewed by Dr. 02/2/10; surgery was noted as not medically necessary. Dr., an orthopedist, did a review on 02/22/10 and did not find the surgery to be medically necessary.

The records provided for this review are unclear as to whether or not the claimant has exhausted conservative care, specifically physical therapy, stretch, strength, range of motion, modalities, and anti-inflammatory medications. It appeared that the claimant was offered surgery immediately after the MRI. The MRI mainly shows degenerative changes with thickening, possibly a small tear with some bursal symptoms. However, the guidelines recommend at least 3-6 months of conservative care prior to surgery and evidence of the patient's participation in PT, if any, was not included in the records. Therefore, the guidelines are not satisfied and the reviewer finds that medical necessity does not exist at this time for ASC Lt shoulder arthroscopy w/subacromial decompression possible RCR and labral repair.

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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)