

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Nov/21/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Rt shlder mumford procedure, ac joint

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

M.D., Board Certified 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**

Official Disability Guidelines and Treatment Guidelines

Adverse determination notice 10/10/11

Adverse determination after reconsideration notice 1024/11

Office notes Dr. 08/10/11-10/24/11

MRI right shoulder 09/29/11 and 07/29/11

Physical therapy initial evaluation and progress notes 08/23/11-09/08/11

Response to request for IRO 11/03/11

Peer review Dr. 09/09/11

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male who was injured on xx/xx/xx when a forklift gas/brake pedal became stuck and he was struck by forklift. He reported injuries to his right shoulder and low back. MRI of right shoulder was reported as normal MRI of shoulder. Repeat MRI dated 09/29/11 revealed minimal AC hypertrophic soft tissue changes without evidence of bone marrow edema or separation; negative MRI examination to glenohumeral joint. Initial physical therapy evaluation on 08/23/11 noted the claimant presented with shoulder syndrome consistent with sprain / strain injury resulting in upper extremity dysfunction. Functional mobility was impaired due to pain, weakness, swelling, joint stiffness, tightness, limited range of motion and overall guarding. The claimant was treated with course of therapeutic exercise program. Records indicate the claimant also underwent injection to AC joint without any relief. Follow-up by Dr. on 09/28/11 indicated the claimant continued with same pain. Injection did not help him. On examination there was tenderness at AC joint, has clicking and popping in AC joint with crossed adduction. There was no palpable swelling, no erythema, normal strength and tone, normal sensation, normal deep tendon reflexes and coordination, normal range of motion, no crepitus, painful active abduction, and no instability subluxation or laxity. The patient was seen in follow-up on 10/05/11 for MRI results. MRI was noted to

confirm injury to AC joint and claimant was recommended to proceed with Mumford.

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

The proposed right-shoulder Mumford procedure, AC joint is not supported as medically necessary by the clinical records submitted for review. The claimant is noted to have sustained an injury to right shoulder when he was struck by forklift. MRI of right shoulder obtained on 07/29/11 was reported as normal study of shoulder.

MRI of AC joint on 09/29/11 revealed minimal hypertrophic soft tissue changes of AC joint without evidence of bone marrow edema or separation, and negative examination of glenohumeral joint. The claimant is noted to have subjective complaints of right shoulder pain. On examination performed on 10/05/11, there was clicking and popping with crossed adduction and painful active adduction, otherwise unremarkable examination. Records indicate the claimant had no benefit from corticosteroid injection. Per ODG guidelines, objective clinical findings include pain relief obtained with injection of anesthetic for diagnostic therapeutic trial. The claimant failed this trial. Given the minimal findings on imaging studies with limited physical examination findings and lack of response to diagnostic injection, the review finds Rt shlder mumford procedure, ac joint is not medically necessary.

**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)