

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right shoulder EUA, diagnostic arthroscopy with debridement, subacromial decompression, Mumford procedure and rotator cuff repair

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
Request for IRO 04/12/12
Utilization review determination 03/26/12
Utilization review determination 04/04/12
Clinical records Dr. 06/09/10-03/19/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have sustained work related injuries on xx/xx/xx. The first available clinical record is dated 06/09/10. The claimant is noted to have a diagnosis of right shoulder impingement, AC joint arthrosis, and subacromial bursitis. The claimant is reported to be doing better. She was not approved for a second functional capacity evaluation and she is doing a home exercise program. She is 5'1" and 135 pounds. She has full symmetric range of motion of the right shoulder when compared to the left. She can return to full duty and she is to participate in home rehabilitation exercises. She saw Dr. on 03/16/11. She has been fired from her employment. She is working part time and is to start an position in the following week. She is taking Naprosyn without complete relief of her right shoulder symptoms. She has a painful arc from 100-150 degrees. She has 4+/5 strength with drop arm test. She is tender over the AC joint. She has positive Neer and Hawkins impingement sign. Internal and external rotations are painful. A home exercise program and anti-inflammatories were recommended by her provider. She saw Dr. again on 09/07/11. She is working two different jobs. She is avoiding too much use of the right upper extremity as Naprelan has helped. She has completed physical therapy. Elevation is to 170 degrees with minimal discomfort. She has 4/5 strength with drop arm test, minimal tenderness to palpation over the AC joint and positive Neer's test. The claimant was continued on activity modification and anti-inflammatories. She saw Dr. on 11/21/11. She is

reported to have right shoulder pain despite conservative management. It is reported that previous MRI did not reveal any rotator cuff tears. Her physical examination is grossly unchanged. The most recent clinical note is dated 03/19/12. She reports having problems with tightness involving the right arm. She reports that symptoms are increasing with excessive activity. She has some interference in activities of daily living. Range of motion is 155 degrees. She has discomfort past 105. She has positive Neer's and Hawkins' impingement sign, limited internal and external rotation with pain at end range of motion. Speed's test is painful. She has 4+/5 drop arm test.

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

This claimant has a chronic history of right shoulder pain. Her symptoms clearly wax and wane in the clinical record and are dependent upon the claimant's activity level. It appears that the claimant has undergone multiple courses of physical therapy with improvement and then exacerbation. The records do not report any significant pathology in the shoulder. There is no indication that the claimant underwent a series of corticosteroid injections. Given the claimant's clinical presentation of waxing and waning symptoms, and the fact that corticosteroid injections have not been employed as of yet, the reviewer finds that Right shoulder EUA, diagnostic arthroscopy with debridement, subacromial decompression, Mumford procedure and rotator cuff repair is not supported as medically necessary at this time.

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)