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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: May/29/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right shoulder scope, SLAP repair, open AC reconstruction

A 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that medical necessity is not established for the right shoulder scope, SLAP repair, open AC reconstruction

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Skilled nursing discharge report 12/03/12
Physical therapy progress reports 11/16/12-02/08/13
Consultation report 09/12/12
Operative report 09/12/12
Radiographs bilateral elbows 09/12/12
Intraoperative spot radiographs right wrist 09/12/12
CT face 09/12/12
CT cervical spine 09/12/12
CT head and brain 09/12/12
CT chest thorax abdomen pelvis 09/12/12
Rehabilitation evaluation 09/20/12
Discharge report 10/04/12
Clinical record no signature 10/04/12
Radiographs left and right olecranon I. Barwari 10/04/12
Clinical record 10/25/12
Radiographs bilateral elbows 10/25/12
Clinical record 11/21/12
Clinical record 12/28/12
Clinical record no signature 01/24/13
MRI right shoulder 01/10/13
MRI right shoulder 02/06/13 with addendum
Clinical record 02/07/13
Clinical record no signature 02/11/13
Clinical record no signature 02/15/13

Radiographs right shoulder 04/18/13
Letter 04/11/13 and 04/23/13
Prior reviews 03/05/13 and 04/16/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx when he fell approximately 35 feet. The patient was status post open reduction internal fixation of right and left epicondylar fractures. The patient was treated post-operatively in a skilled nursing level through 12/12. The patient was attending physical therapy through 02/13. There were indications that the patient fell on the right shoulder and initial MRI of the right shoulder on 01/10/13 demonstrated osteoarthritis of the right acromioclavicular joint with a normal appearing rotator cuff without evidence of tearing. The labrum revealed no gross tearing with a biceps anchor appearing intact. This was a non-arthrographic study. A repeat MRI of the right shoulder on 02/08/13 identified no evidence of partial or full thickness rotator cuff tearing. There was fluid in the central inner fibers of the supraspinatus tendon. A small amount of glenohumeral joint effusion was present and there was no evidence of acromioclavicular separation. No evidence of labral pathology was identified in this study. The patient was recommended for further physical therapy on 02/07/13. Clinical note on 02/11/13 indicated that the patient also was diagnosed with a brachiolexus injury. Physical examination reported a positive apprehension sign in the right upper extremity with tenderness over the anterior shoulder. There was also tenderness over the greater tuberosity in the right shoulder. Review of imaging studies felt that there was partial thickness tearing of the supraspinatus tendon and inferior labral damage. Follow up on 02/15/13 indicated that the patient had positive O'Brien signs with severe tenderness over the acromioclavicular joint. Radiographs of the right shoulder on 04/18/13 identified a superior dislocation of the distal right clavicle relative to the acromion measuring approximately 9-10mm. No fracture or dislocation of the right glenohumeral joint was identified. The request for a right shoulder arthroscopy with acromioclavicular reconstruction and SLAP repair was denied by utilization review on 03/05/13 as there was no official imaging study for the right shoulder and there was no clinical documentation regarding further physical therapy as recommended. The request was again denied by utilization review on 04/16/13 as there was no clinical documentation regarding conservative treatment for the right shoulder.

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

The patient sustained a substantial injury to the upper extremities due to the 35 foot fall reported on the date of injury. The most recent imaging of the right shoulder failed to identify any evidence of labral pathology that would reasonably require SLAP repairs as requested. The most recent radiograph identified a superior dislocation of the distal right clavicle as relative to the acromion measuring 9-10mm. It is unclear from this imaging study whether the patient has had multiple reproducible dislocations. As previously indicated in the prior reviews there is insufficient documentation regarding a physical therapy program for the right shoulder that has failed to improve any of the reported symptoms. There was also no updated orthopedic evaluation since 02/13. As the clinical documentation submitted for review does not support the requested surgical procedures as recommended by current evidence based guidelines, it is the opinion of this reviewer that medical necessity is not established for the right shoulder scope, SLAP repair, open AC reconstruction and the prior denials are upheld.

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)