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SECOND AMENDED NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: May/06/2013

DATE AMENDED NOTICE SENT TO ALL PARTIES: May/14/2013

DATE SECOND AMENDED NOTICE SENT TO ALL PARTIES: May/15/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: RT shoulder scope subacromial decompression, open long head tendon repair

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 the requested RT shoulder scope subacromial decompression, open long head tendon repair is not medically necessary and the prior denials are upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes 02/19/13-03/28/13
Therapy notes 03/12/13-03/28/13
Previous utilization reviews 03/04/13 and 04/10/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury regarding his right shoulder. Clinical note dated 02/19/13 detailed the patient complaining of right shoulder pain described as severe and sharp with a moderate aching. The patient stated that the initial injury occurred from continuous overhead work and repetitive motions. The patient utilized hydrocodone for ongoing pain relief. MRI of the right upper extremity dated 12/19/12 revealed a complete tear of the long head of the biceps tendon from the intrascapular region through the bicipital groove. The long head of the biceps was severely torn at the attachment. Clinical note dated 03/08/13 detailed the patient having full passive range of motion. The patient demonstrated 3/5 strength throughout the shoulder. Clinical note dated 03/28/13 detailed the patient showing an increase in activities. The patient was noted to not have a Cortisone injection at that time. The therapy note dated 03/28/13 details the patient having completed 2 full weeks of therapy.

The previous utilization review dated 03/04/13 details the request for a right shoulder scope subacromial decompression and open long tendon repair had resulted in a denial secondary

to no information regarding the patient's previous attempted injection or therapy. Additionally, the findings of the biceps rupture were noted to be chronic as the age of the injury was known to be greater than 3 months old.

The utilization review dated 04/10/13 resulted in a denial for the right shoulder scope subacromial decompression and open long head tendon repair secondary to the injury being chronic in nature as the date of injury was noted to be greater than 3 months old. Additionally, the patient was noted to have not exhausted a 3 month course of conservative treatments.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient complaining of right shoulder pain. The Official Disability Guidelines recommend a subacromial decompression provided the patient meets specific criteria to include completion of all conservative therapy as well as an injection therapy. The patient is noted to have completed a 2 week course of physical therapy related to the right shoulder complaints; however, no information was submitted regarding the patient's completion of a full 3 month course of therapy. Additionally, no information was submitted regarding the patient's completion of injection therapy at the right shoulder. Given that no information was submitted regarding the patient's completion of a 3 month course of conservative therapy, this request does not meet guideline recommendations. As such, it is the opinion of this reviewer that the requested RT shoulder scope subacromial decompression, open long head tendon repair is not medically necessary 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)