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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/02/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left shoulder arthroscopic acromioplasty

A 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)

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 request for a left shoulder arthroscopic acromioplasty is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his left upper extremity. The operative report dated 01/25/13 indicates the patient undergoing an arthroscopy at the right shoulder. The clinical note dated 02/01/13 indicates the patient undergoing postoperative therapy following the right shoulder procedure. The patient was utilizing Tylenol #3 and Valium for ongoing pain relief. The clinical note dated 12/13/13 indicates the patient complaining of elbow and wrist pain secondary to an incident. The patient was in moderate distress secondary to right elbow pain. The clinical note dated 12/18/13 indicates the patient having full range of motion at the left elbow with no significant abnormalities. However, the patient did have complaints of pain at the lateral epicondyle and over the biceps. The clinical note dated 01/07/14 indicates the patient having continued complaints of left elbow pain. X-rays of the elbow revealed essentially normal findings. The clinical note dated 01/21/14 indicates the patient having complaints of left shoulder pain secondary to a fall on ice.

The MRI of the left shoulder dated 01/23/14 revealed a type 2 acromion with mild hypertrophic spurring in the acromioclavicular joint. Mild subacromial space narrowing was also identified. The therapy note dated 01/28/14 indicates the patient having completed 9 physical therapy sessions to date. However, it appears the focus of the therapy was for the left elbow and not particularly for the shoulder. The patient was able to demonstrate 135 degrees of left shoulder flexion, 120 degrees of abduction, 85 degrees of internal rotation, and 65 degrees of external rotation. The clinical note dated 01/28/14 indicates the patient having complaints of tenderness at the anterior acromial region. The clinical note dated 02/18/14 indicates the patient complaining of 6/10 shoulder pain with a positive impingement sign. The clinical note dated 03/11/14 indicates the patient continuing with a positive

impingement sign with associated weakness with abduction and forward flexion.

The utilization review dated 01/31/14 resulted in a denial as no indication of the patient completing a full course of physical therapy addressing the left shoulder complaints was submitted.

The utilization review dated 02/07/14 resulted in a denial as no significant treatment had been completed addressing the shoulder complaints.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of left elbow and shoulder pain. A left shoulder arthroscopic acromioplasty would be indicated provided the patient meets specific criteria to include completion of all conservative treatments. There is a history of involvement with physical therapy. However, the therapy notes indicate the focus of the treatment was towards the left elbow with very minimal care addressing the shoulder. Given these findings, it does not appear that the patient has completed all conservative treatments addressing the left shoulder complaints prior to a surgical intervention. As such, it is the opinion of this reviewer that the request for a left shoulder arthroscopic acromioplasty is not recommended as 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)