

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/15/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right shoulder arthroscopy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery, Sub Specialty Orthopedic Sports Medicine

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 right shoulder arthroscopy is not recommended as medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
Clinical note dated 03/27/14  
Clinical note dated 05/14/14  
MRI of the right upper extremity dated 03/31/14  
MRI of the right upper extremity dated 04/14/14  
Therapy notes dated 04/03/14 & 05/05/14  
Adverse determinations dated 05/29/14 & 06/06/14

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female who reported an injury to her right shoulder. The clinical note dated 03/27/14 indicates the patient complaining of right shoulder pain that was rated as 6/10. The patient described an immediate sharp pain following the initial incident. The patient subsequently reported tingling in the 4th and 5th fingers with shoulder flexion. The note indicates the patient having a positive empty can and O'Brien's test. The therapy note dated 04/03/14 indicates the patient having initiated physical therapy at that time. The MRI arthrogram of the right shoulder dated 04/14/14 revealed findings consistent with a shallow superior labral tear posterior to the anchor. The rotator cuff was identified as being intact. The therapy note dated 05/05/14 indicates the patient having undergone 6 physical therapy sessions to date. The patient continued to rate the pain as 5-8/10. The clinical note dated 05/14/14 indicates the patient continuing with physical therapy. The patient stated that all daily activities are exacerbating her pain. The patient was recommended for a diagnostic arthroscopy with a possible labral repair.

The utilization review dated 05/29/14 resulted in a denial as no significant functional limitations were identified at the right shoulder. Additionally, no information had been submitted regarding the completion of any conservative treatments.

The utilization review dated 06/06/14 indicates the patient having no significant functional limitations.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The documentation indicates the patient complaining of right shoulder pain. A diagnostic arthroscopy is indicated for patients who have continued with functional limitations at the shoulder despite the completion of all conservative treatments. No information was submitted regarding the patient's completion of a 3 month course of conservative therapy. Additionally, no information was submitted regarding the patient's significant functional deficits at the right shoulder. As such, it is the opinion of this reviewer that the request for a right shoulder arthroscopy is not recommended as medically necessary.

**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)