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DATE NOTICE SENT TO ALL PARTIES: May/05/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Right shoulder ATS, Labral Bankart with Extensive Debridement

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 the request for Right shoulder ATS, Labral Bankart with Extensive Debridement is medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male with complaints of shoulder pain. On XX/XX/XX, an MRI of the shoulder revealed a superior labral tear with anterior and posterior extension and extension into the biceps labral anchor. There was no evidence of rotator cuff tear. There was multifocal areas, full thickness cartilage defect along the inferior and posterior glenoid with subchondral fissuring. On XX/XX/XX, the patient reported continued pain to the shoulder. He reported trouble sleeping due to his pain. The exam found right shoulder range of motion was restricted. There is a positive Hawkins and Speed's test and there was a painful arc syndrome. On XX/XX/XX, the patient returned to clinic. He continued to report right shoulder pain, popping and instability. Exam on the right shoulder revealed painful arc motion to the shoulder, and positive anterior drawer test and positive anterior instability testing. Hawkins test was positive. Surgery was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On XX/XX/XX, an adverse determination letter was submitted for a requested arthroscopic shoulder repair of the SLAP lesion and extensive shoulder debridement, and the request was non-certified using Official Disability Guidelines Shoulder Chapter as the rationale. There was no documentation of a history of multiple dislocations that inhibited activities of daily living, and no positive apprehension testing on exam was noted or documented dislocation of the anesthesia. The guidelines required a history of multiple dislocations that inhibit activities of daily living. Therefore, the request was non-certified. On XX/XX/XX, an adverse determination was submitted and no additional documentation was submitted. The request remained non-certified as there was lack of documentation of recurrent disc locations or evidence of instability on exam such as apprehension testing or documented dislocation under anesthesia.

For the Bankart labral repair, the guidelines state that there should be documentation of either dislocations or SLAP type II or type IV lesions.

The records document superior labral tear with anterior and posterior extension and extension into the biceps labral anchor. On exam, there is a painful arc motion to the shoulder, and positive anterior drawer test and positive anterior instability testing. Hawkins test was positive.

It is the opinion of this reviewer the request for Right shoulder ATS, Labral Bankart with Extensive Debridement is medically necessary and the prior denials are overturned.

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)