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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: X

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)
- Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for **each** of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW: • X

PATIENT CLINICAL HISTORY [SUMMARY]: X who was injured on X. X stated X had X. The diagnosis was primary osteoarthritis of the left shoulder; incomplete rotator cuff rupture of left shoulder, not specified as traumatic; and pain in left shoulder. On X, X was evaluated by X, DO for left shoulder pain that was mild-to-moderate, occurred constantly and was fluctuating. The pain radiated to the left elbow. It was described as aching, piercing, and sharp. It was aggravated by bending and lifting. The pain was relieved by X. Associated symptoms included decreased mobility, joint instability, joint tenderness, numbness, popping, and weakness. X presented that day for a follow up for the left shoulder after receiving a X on X. X reported slight relief to the left shoulder after the X. X continued to feel sharp pain when rotating the shoulder and heard cracking and popping. X attended X. X reported having numbness when resting the arm parallel to the ground. On examination, X was irritable but consolable, due to pain. X was obese. Left shoulder examination revealed X. Active range of motion showed external rotation X degrees, abduction X degrees, flexion X degrees, abduction X degrees. The assessment was primary osteoarthritis of the left shoulder; incomplete rotator cuff rupture of left shoulder, not specified as traumatic; and pain in left shoulder. Given X recurrence of symptoms and X lack of Improvement with conservative management, Dr. X discussed the risks, benefits, and complications of the X. An MRI of the left shoulder dated X, was done for left shoulder pain, and X. There was X. Treatment to date included X. Per a utilization review adverse determination letter dated X, the request for X was denied by X, MD. Rationale: "The Official Disability Guidelines state that X. X, is advised for at least X months, as most flare-ups are temporary. X is considered if there is X. For X, is documented on imaging, shows no improvement after X months of X. X is considered when significant X. It serves as an X. X is more suitable for patients older than X. The request was not supported. The claimant has documented functionally limiting left shoulder pain. However, the physical examination findings are lacking within the medical records. A phone call to the office of X, DO at X was placed on X. The provider was unavailable. However, a conversation was held with X, PA-C regarding the requested care and discussed the deficiency. X

will discuss with Dr. X to get updated findings for the claimant however none were provided to me at the time of this review and submission. Based on the lack of objective findings that correlate with the imaging, surgical intervention cannot be certified at this time. As such, the request for a X. Assist: X, PA is not supported. Recommended for non-certification. "Per a reconsideration review adverse determination letter dated X, the appeal request for X; assist: X, PA, X was denied by X, MD. Rationale: "The Official Disability Guidelines support X. There should be physical examination findings of tenderness at the X. This injured employee has complaints of left-sided shoulder pain, not specifically identified at the X. There has been an improvement in X. However, physical examination notes X. There is an isolated physical examination finding a cross-body test. MRI shows X. However, considering the absence of objective findings to correlate with subjective complaints, a X is not supported. Regarding X. Furthermore, guidelines would only support X. Guidelines would also only support the use of an assistant surgeon for complex surgery such as spinal surgery. This request is for a routine X. Previous reviews also do not certify this request due to lack of physical examination findings. Overall, this request for a X, Assist: X, PA, is non-certified, Peer-to-peer was unsuccessful. Based on the submitted documentation, there are insufficient examination findings to correlate with the imaging findings which would warrant the requested procedure. A X is not indicated given the lack a X. A X is not indicated for the requested procedure given the lack of complexity. No new information has been provided which would overturn the previous denials. X is not medically necessary and non-certified.

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

Based on the submitted documentation, there are insufficient examination findings to correlate with the imaging findings which would warrant the requested procedure. A X is not indicated given the lack a X. A X is not indicated for the requested procedure given the lack of complexity. No new information has been provided which would overturn the previous denialsX is not medically necessary and non-certified.

Upheld

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- PRESLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**