

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/01/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient right shoulder manipulation under anesthesia

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

M.D., board certified in 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 2/12/09, 2/27/09

ODG Guidelines and Treatment Guidelines

MD, 11/10/08

MRI, 10/15/08

TX Orthopaedics, 11/3/08, 2/2/09

Physical Therapy, 1/12/09, 2/2/09, 1/14/09-2/12/09, 2/2/09

RN, 3/10/09

Dr. DO, 12/4/08

Doctor Notes, 10/9/08, 10/15/08

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who sustained an injured rotator cuff in xx/xxxx, and underwent a rotator cuff repair in December 2008, more than xxxxx months ago. He has been well except for some loss of range of motion noted. He has had physical therapy. The previous reviewer denied this procedure on the basis it had not been sufficient time since surgery passed based on ODG Guidelines. The current request is for manipulation under anesthesia.

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

This patient underwent a rotator cuff repair surgery more than xxx months ago. The records indicate that a sufficient amount of time has passed along with physical therapy that his range

of motion should have returned to normal by this time in accordance with the ODG Guidelines. Based on the lack of return to full range of motion and/or acceptable range of motion, it is not unreasonable for the medical provider to request manipulation under anesthesia to hopefully avoid a less than perfect outcome for the procedure that was clearly medically indicated. The request meets the ODG Guidelines. It is for this reason that this reviewer feels that at this point, greater than three months post surgery, that the medical necessity is supported by the medical records and the ODG Guidelines are met. The reviewer finds that medical necessity exists for Outpatient right shoulder manipulation under anesthesia.

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)