

Notice of Independent Review Decision

IEWER FINAL REPORT

DATE OF REVIEW: 7/16/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Manipulation with possible left shoulder arthroscopy (29826 and 23700)

QUALIFICATIONS OF THE REVIEWER:

Neurosurgery, Surgery Spine

REVIEW OUTCOME:

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

Manipulation with possible left shoulder arthroscopy (29826 and 23700) Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Notice to Air Analyses by, dated 6/25/2010
2. Fax page dated 6/23/2010
3. Request for a review by author unknown, dated 6/21/2010
4. IRO online submission information prep sheet dated 6/15/2010
5. Notification by author unknown, dated 5/26/2010 & 6/15/2010
6. Fax page dated 6/25/2010
7. Notice to utilization review by, dated 6/25/2010
8. Request for a review dated 6/21/2010
9. Clinical note by MD, dated 6/15/2010
10. Letter by DO, dated 5/26/2010
11. Notification by author unknown, dated 5/26/2010 & 6/15/2010
12. Fax page dated 4/27/2010
13. Request for preauthorization dated 4/24/2010
14. Plan of care by MD, dated 4/23/2010
15. Prescription note by author unknown, dated 4/21/2010
16. Fax page dated 3/26/2010 & 4/1/2010
17. Work status report by author unknown, dated 3/26/2010 & 4/1/2010
18. Bone growth stimulator prescription dated 3/22/2010
19. Fax page dated 3/13/2010
20. Office visit by author unknown, dated 3/11/2010
21. Employers first report of injury by author unknown, dated 3/8/2010
22. Request for preauthorization by, dated 2/24/2010
23. Form by author unknown, dated unknown
24. Notice to utilization review by, dated 6/25/2010
25. Request for a review by author unknown, dated 6/21/2010
26. Letter by MD, dated 6/15/2010
27. Letter by DO, dated 5/26/2010
28. Notice by author unknown, dated 5/26/2010 & 6/15/2010
29. Fax page dated 4/27/2010
30. Plan of care by PT, dated 4/23/2010
31. Prescription note by author unknown, dated 4/21/2010
32. Work status report by author unknown, dated 3/26/2010 & 4/1/2010
33. Fax page dated 4/1/2010

Name: Patient_Name

34. Fax page dated 3/26/2010
35. Bone growth stimulator prescription by author unknown, dated 3/22/2010
36. Bone growth stimulator medical necessity summary dated 3/22/2010
37. Fax page dated 3/13/2010
38. Office visit by author unknown, dated 3/11/2010
39. Employers first report by author unknown, dated 3/8/2010
40. Request for authorization by, dated 2/24/2010
41. Form by author unknown, dated unknown
42. Request for preauthorization by author unknown, dated unknown
43. Official Disability Guidelines (ODG)

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a female who sustained an injury on xx/xx/xx when she tripped and fell, injuring her left shoulder. A clinical note from Dr. on 03/11/2010 indicated the injured employee had an obvious fracture of the proximal humerus with gross instability. Radiographs taken in clinic confirmed a humeral neck fracture with a fracture of the tuberosity. She was recommended for open reduction internal fixation. She was then evaluated for physical therapy on 04/23/2010. She underwent open reduction with internal fixation (ORIF) of the left humerus on 03/24/2010. The injured employee stated she had been performing grip exercises and pendulum exercises at home. Objective examination was deferred regarding active range of motion and strength due to cervical precautions. Passive range of motion to the left was restricted as expected with severe limitations on flexion and abduction below 50 degrees. She was recommended for physical therapy to include passive and active range of motion.

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

The clinical documentation provided for review does not support manipulation with possible left shoulder arthroscopy. No updated imaging studies were submitted for review demonstrating the evidence of a SLAP lesion that would require the surgical repair. Additionally, the injured employee's current status regarding the left shoulder is unknown, and it is unclear if post-operative physical therapy provided any significant results in improving the injured employee's range of motion. In accordance with ODG, the clinical documentation does not support either request for surgery. The recommendation is to uphold the previous denials.

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
- 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)