



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 05/31/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left shoulder outpatient manipulation under anesthesia

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

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

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
726.0	23700		Prosp.						Overturn
832.01	23700		Prosp.						Overturn

INFORMATION PROVIDED FOR REVIEW:

1. Certification of independence of reviewer and TDI case assignment
2. TDI case assignment
3. Letters of denial, 04/29/10 and 05/06/10 including criteria used in denial
4. Radiology reports, 12/26/09 through 02/12/10
5. Treating doctor's evaluation and office visits, 01/22/10 through 04/29/10
6. Emergency room record, 12/26/09
7. Report of medical evaluation, 04/20/10

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient suffered an anterior glenohumeral joint dislocation that was reduced in the emergency room. Post injury the patient suffered from significant adhesive capsulitis. An orthopedic surgeon treated him with physical therapy and conservative care including a home exercise program, stretching, and multiple steroid injections. He continued to have significant pain, weakness, and limited motion. Manipulation under anesthesia was recommended. The patient elected to proceed with this. The insurance company denied this due to the lack of documentation on the request.

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

The patient meets the ODG criteria for manipulation under anesthesia. The patient has failed extensive conservative management and has significant functional and objective deficits in range of motion. Manipulation under anesthesia is medically reasonable and necessary based on the ODG Guidelines and the documentation provided for this review.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)