

Prime 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: August/29/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

One left shoulder manipulation under anesthesia one assistant surgeon one corticosteroid injection for the left shoulder

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

MD, 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

Official Disability Guidelines
Request for IRO 08/11/11
MRI cervical spine 10/12/09
MRI left leg 10/12/09
MRI lumbar spine 10/12/09
Clinical records Dr. 01/04/10 through 07/12/11
MRI left shoulder 01/28/10
EMG/NCV study upper extremities 02/16/10
Physical therapy evaluation 06/03/11
Physical therapy progress notes
Operative report 04/13/11
Utilization review determination 07/21/11
Utilization review determination 08/04/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male. He sustained injuries. On xx/xx/xxxx his vehicle was struck from the rear by a flatbed truck. He injured his cervical and lumbar spine, left hip and left shoulder. He came under the care of Dr. on 01/04/10. Imaging studies revealed disc herniations at C3-4 C4-5 and C6-7. MRI of the lumbar spine revealed a grade 1 anterolisthesis at L5-S1 with bilateral foraminal stenosis. The claimant was referred for MRI of the left shoulder which indicated bone marrow contusion through the humeral head, which was non-displaced with complete rotator cuff tear with minimal retraction at the critical area of insertion of the supraspinatus tendon. The records note that the claimant underwent EMG/NCV studies of the left shoulder and lower neck, which showed evidence of a moderate median sensory and motor neuropathy with no evidence of cervical radiculopathy. He was taken to surgery on 04/13/11 at which time he underwent a glenohumeral debridement and rotator cuff repair. Post-operatively he was referred for aggressive post-operative physical therapy. When seen in follow up on 05/19/11 he is reported to have only completed two weeks of physical therapy.

He had significant reductions in range of motion -- abduction is to 85 degrees with limited internal and external rotation. Additional physical therapy was recommended. On 07/12/11 the claimant was seen in follow-up by Dr. who reported the claimant has developed adhesive capsulitis and frozen shoulder. On physical examination the claimant continues to have limited range of motion with abduction to 85 degrees with limited internal and external rotation. Manipulation under anesthesia was recommended.

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

This claimant sustained an injury to his shoulder with full thickness rotator cuff tear. He was taken to surgery on 04/13/11 and referred for postoperative physical therapy. He has continued restrictive range of motion and is limited to 85 degrees in abduction, essentially no internal or external rotation. The claimant's examination clearly indicates he is arthrofibrosed. The provider has noted that no amount of additional conservative treatment will result in any functional improvements given the presence of adhesions. The request for one left shoulder manipulation under anesthesia one assistant surgeon one corticosteroid injection for the left shoulder is consistent with ODG guidelines and current standards of orthopedic care. The reviewer finds that medical necessity exists for One left shoulder manipulation under anesthesia one assistant surgeon one corticosteroid injection for the left shoulder.

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)