

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/21/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Shoulder Manipulation Under Anesthesia

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

M.D., Board Certified Orthopedic Surgeon

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

ODG Treatment Guidelines

Utilization review determination 11/11/11

Reconsideration / appeal of adverse determination 11/28/11

Utilization review / provider request form 11/08/11

General orthopedic clinic notes Dr. 09/21/11 and 11/07/11

Physical therapy referral

MRI lumbar spine 07/14/11

X-rays left shoulder 09/19/11

X-rays right shoulder 09/19/11

MRI left shoulder 07/14/11

Operative report right shoulder excision of distal clavicle, acromioplasty and rotator cuff debridement 04/28/11

MRI arthrogram right shoulder 03/22/11

Office notes Dr. 04/11/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained an injury to his left shoulder in xx/xx. He was injured when he was holding a pipe with both arms, which were pulled very drastically in a downward direction. He has been seen in the past by Dr. who attempted an open rotator cuff repair, who per the claimant's report states he was unable to do repair due to magnitude of rotator cuff tear. He has had physical therapy since that surgery and reported getting no better. He reported having less range of motion after surgery than before. He sought care from Dr. on 11/07/11. He is noted to have diagnosis of right shoulder adhesive capsulitis, right shoulder rotator cuff tear, left shoulder adhesive capsulitis, and left shoulder rotator cuff tear. On physical examination on this date the claimant is 5'6" tall and weighs 190 lbs. On examination of right upper extremity his active range of motion is limited

to 45 degrees of flexion and 45 degrees of abduction. He can passively be ranged to 90 degrees of abduction and 90 degrees of flexion before stiffness is encountered with significant pain. He has tenderness to palpation over the superior aspect of the shoulder, and he has positive Hawkins and positive drop arm test. On examination of left upper extremity he can actively flex and abduct shoulder to 45 degrees and passively to 90 degrees in flexion and abduction. He has positive drop arm test. Pain is elicited after 90 degrees of abduction and flexion. He has some pain over acromion and AC joint. Prior imaging showed left shoulder full thickness tear of supraspinatus at humeral attachment that is 5x4 cm in dimension. He was subsequently recommended to undergo manipulation under anesthesia. Radiographs of the left shoulder performed on 09/19/11 showed no evidence of fractures or dislocations. The humeral head is smooth and irregular. There is mild hypertrophy of left acromioclavicular joint.

MRI of the left shoulder was performed on 07/14/11. This study notes a complete full thickness tear of supraspinatus tendon at its humeral attachment with proximal retraction of torn tendon edge. This results in cuff defect estimated at 5x4 cm. There is an adjacent partial tear of the superior fibers of the infraspinatus tendon involving bursal side as well as articular surface. There is a near complete tear of subscapularis tendon with some sparing of inferior fibers. The mid and superior fibers are severely attenuated and paper-thin. The remainder of rotator cuff was intact. There is mild atrophy of supraspinatus and subscapularis muscle bellies. The remaining musculature is within normal limits. The humeral head is shifted upward causing narrowing of subacromial space. There is type I acromion which minimally contacts the humeral head. There is acromioclavicular joint hypertrophy, which appears to act as impinging lesion as well. There is no definite sign of acute labral tear. The capsule is somewhat redundant which could be due to chronic partial tear. The long head of biceps tendon appears quite attenuated within the bicipital groove. No full thickness injury is seen. There is a moderate sized joint effusion with fluid in subcoracoid and subacromial bursa. There is no bone contusion, fracture or stress fracture. The request is for left shoulder manipulation under anesthesia.

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

This man sustained injuries to bilateral shoulders as result of work place activity. Imaging studies of his left shoulder showed evidence of full thickness rotator cuff tear. He has had extensive conservative treatment with no apparent improvement and continued limitations in range of motion. The examination as presented by Dr. indicates that the patient has 45 degrees of active range of motion and only 90 degrees of passive range of motion with firm end point establishing diagnosis of adhesive capsulitis. Had his limitation in motion been strictly secondary to rotator cuff tear, then one would anticipate a much greater passive range of motion on examination without true firm end point. Provider states the claimant has developed adhesive capsulitis secondary to disuse of bilateral shoulders. Based on the records submitted, and the evidence-based guidelines, the reviewer finds that medical necessity exists for Left 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 KNOWLEDGBASE

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)