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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: outpatient right shoulder manipulation under anesthesia

A 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. Based on the clinical documentation provided for review and current evidence based guideline recommendations regarding manipulation under anesthesia, medical necessity for the requested outpatient right shoulder manipulation under anesthesia is not established.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

- 11/04/11 – Clinical Note – DO
- 11/08/11 – Physical Therapy Note
- 11/22/11 – Physical Therapy Note
- 11/29/11 – Physical Therapy Note
- 12/01/11 – Clinical Note –, DO
- 12/23/11 – Clinical Note –, PA-C
- 01/05/12 – Clinical Note –, MD
- 02/07/12 – Clinical Note –, MD
- 02/08/12 – Operative Report
- 02/14/12 – Clinical Note –, MD
- 03/28/12 – Physical Therapy Note
- 04/04/12 – Physical Therapy Note
- 04/10/12 – Physical Therapy Note
- 04/12/12 – Physical Therapy Note
- 04/17/12 – Physical Therapy Note
- 04/19/12 – Physical Therapy Note
- 04/24/12 – Physical Therapy Note
- 04/26/12 – Physical Therapy Note
- 05/01/12 – Physical Therapy Note
- 05/03/12 – Physical Therapy Note
- 05/03/12 – Clinical Note –, MD

05/07/12 – Procedure Scheduling Request
05/08/12 – Physical Therapy Note
05/14/12 – Notice Of Utilization Review Findings
05/18/12 – Notice Of Utilization Review Findings
06/11/12 – Correspondence – FOL

PATIENT CLINICAL HISTORY [SUMMARY]

The claimant is a male with complaints of right shoulder pain. The claimant saw Dr. on 02/07/12 with complaints of persistent anterior right shoulder pain. Physical exam revealed limited cervical range of motion. Exam of the right shoulder revealed periscapular deconditioning and dyskinesia. There was pain with external rotation. O'Brien's was markedly positive. There was tenderness at the subscapularis tendon near the bicipital groove. Hawkins's sign was mildly positive. The claimant was assessed with acute subscapularis tendon full thickness tear, probable proximal biceps tendinopathy, and secondary impingement syndrome. The claimant underwent diagnostic right shoulder arthroscopy, arthroscopic subacromial decompression, superior labrum anterior and posterior repair, subscapularis tendon repair, supraspinatus tendon repair, extensive debridement, limited synovectomy, and intra-articular injection on 02/08/12.

The claimant saw Dr. on 02/14/12. Physical exam revealed swelling of the bilateral hands and legs. There was pitting edema in the lower extremities. The incisions were healing well. There was no evidence of infection. The claimant was seen for physical therapy evaluation on 03/28/12. The claimant complained of right shoulder pain. Active range of motion of the right shoulder revealed flexion to 75 degrees and scaption to 75 degrees. Passive range of motion revealed flexion to 115 degrees and scaption to 120 degrees. The claimant was recommended for 8 to 18 sessions of physical therapy. The claimant completed 10 sessions of physical therapy from 03/28/12 through 05/03/12. The claimant was seen for physical therapy on 05/03/12. The claimant complained of continued right shoulder pain rating 4 out of 10. Active shoulder flexion was to 130 degrees post treatment and active shoulder scapation was to 100 degrees post treatment. The claimant was recommended for continued physical therapy.

The claimant saw Dr. on 05/03/12 with complaints of right shoulder stiffness despite physical therapy. Physical exam revealed well-healing portals without sign of infection. Glenohumeral abduction was to 60 degrees and forward elevation was to 70 degrees. Internal and external rotation was markedly limited. The claimant was assessed with post-operative ankylosis status post right shoulder surgery. The claimant was recommended for right shoulder manipulation under anesthesia. The request for outpatient right shoulder manipulation under anesthesia was denied by utilization review on 05/14/12 as the course of conservative post-operative treatment had been insufficient to meet ODG recommendations. The request for outpatient right shoulder manipulation under anesthesia was denied by utilization review on 05/18/12 as the documentation provided does not support a substantial change in the injured worker's condition.

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

This claimant underwent arthroscopic subacromial decompression and rotator cuff repair in February of 2012. To date the claimant has completed 10 sessions of physical therapy following surgical intervention. The claimant's current range of motion of the right shoulder is limited; however, current evidence based guidelines recommend that patients exhaust 3-6 months of continued conservative physical therapy. There is no evidence in the clinical documentation to establish that the claimant reached a plateau with standard physical therapy to warrant manipulation under anesthesia. The clinical documentation provided for review does not meet guideline recommendations for the requested service. Based on this clinical documentation and current evidence based guideline recommendations regarding manipulation under anesthesia, medical necessity for the requested outpatient right shoulder manipulation under anesthesia is not established.

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)