

Notice of Independent Review Decision

**August 6, 2013**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Right Shoulder Manipulation under Anesthesia

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. The physician has been in practice since 1982 and is licensed in Texas and Oklahoma.

**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 of the health care services in dispute.

*Upon independent review, I find the previous adverse determination should be upheld.*

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

Records Received: 18 page fax 07/19/13 Department of Insurance IRO request, 21 pages received via Fax 07/19/13 URA response to disputed services including administrative and medical. 22 pages received via Fax 07/30/13 Provider response to disputed services including administrative and medical. Dates of documents range from xx/xx/xx (DOI) to 07/19/13.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This female was injured xx/xx/xx with the mechanism of injury being that she jerked her arm back to avoid being scratched by a cat with immediate onset of

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pain. The patient was seen with notation she had failed conservative care with physical therapy. He did do a subacromial injection and subsequently took the patient to surgery 05/02/13, where a manipulation under anesthesia with arthroscopic acromioplasty, bursectomy, and AC joint debridement of the right shoulder was performed without incident. Postoperatively, continued to follow the patient, prescribing physical therapy and medication. noted 05/18/13 in follow-up the patient had developed adhesive capsulitis with markedly restricted active/passive range of motion, noting progressive worsening of motion. Exam noted 80 degrees abduction, flexion 85, internal rotation 60, external rotation 30 degrees.

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

The rationale for recommending noncertification of the request is the patient has not exhausted conservative treatment as recommended by *ODG* as prior to considering a manipulation under anesthesia, *ODG* recommends failing conservative therapy lasting at least three to six months, and at this time, the patient has not failed appropriate treatment for appropriate time frame.

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## 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)