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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/04/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left shoulder capsular release, left 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. It is the opinion of this reviewer that the request for left shoulder capsular release, left shoulder manipulation under anesthesia is recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical note dated 04/26/12
Clinical note dated 05/03/12
Clinical note dated 05/11/12
Clinical note dated 05/25/12
Clinical note dated 07/18/12
Clinical note dated 08/13/12
Clinical note dated 08/27/12
Clinical note dated 09/10/12
Clinical note dated 11/01/12
Clinical note dated 11/13/12
Clinical note dated 04/03/13
Clinical note dated 04/16/13
Clinical note dated 06/17/13
Clinical note dated 09/19/13
Clinical note dated 10/03/13
MR arthrogram of the left shoulder dated 06/22/12
Therapy note dated 06/15/12
Therapy note dated 12/19/12
Therapy note dated 06/29/12
Radiology report dated 04/27/12
Therapy note dated 02/12/13
Functional capacity evaluation dated 09/13/12
Adverse determinations dated 10/19/13 & 10/15/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who reported an injury regarding her left shoulder when she had a slip and fall on a wet floor. The clinical note dated 04/26/12 indicates the patient complaining of low back and bilateral shoulder pain. The note indicates the patient utilizing Advil, Naproxen, and Flexeril for ongoing pain relief. The MR arthrogram of the left shoulder dated 06/22/12 indicates the patient having a type 2 acromion that was downsloping. Mild supraspinatus tendinopathy was noted. Capsular hypertrophy was noted at the AC joint. The clinical note dated 07/18/12 indicates the patient complaining of left shoulder pain with radiating pain to the upper extremity. The note indicates the patient having undergone physical therapy with no significant benefit. Upon exam, the patient was able to passively demonstrate 145 degrees of elevation, 40 degrees of external rotation, and 30 degrees of internal rotation. No strength deficits were noted. The clinical note dated 09/10/12 indicates the patient continuing with complaints of left shoulder pain. The peer review dated 04/16/13 indicates the patient continuing with light duty. The note indicates the patient having undergone chiropractic treatments as well as physical therapy. The functional capacity evaluation revealed the patient able to perform at a light medium physical demand level. The clinical note dated 06/17/13 indicates the patient rating her left shoulder pain as 5/10. The note does mention the patient having completed 15 physical therapy sessions with no improvement. Shoulder pain was noted at the superior portion of the shoulder as well as at the lateral region. The patient was noted to have no significant strength deficits. The patient was able to demonstrate 100 degrees of active flexion, 80 degrees of abduction, 40 degrees of internal rotation, and 10 degrees of external rotation. The clinical note dated 09/19/13 indicates the patient continuing with left shoulder pain with associated range of motion deficits. The clinical note dated 10/03/13 indicates the patient utilizing Ibuprofen at home to address the ongoing left shoulder complaints.

The utilization review dated 10/09/13 resulted in a denial for manipulation under anesthesia at the left shoulder as no information was submitted regarding the patient's range of motion deficits to be delineated between active and passive ranges.

The utilization review dated 10/15/13 resulted in a denial for manipulation under anesthesia as the patient's clinical findings had not been clarified at that time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient complaining of left shoulder pain with associated range of motion deficits. Manipulation under anesthesia is indicated provided the patient meets specific criteria to include the patient being refractory to conservative therapy lasting 3-6 months and the patient is noted to have significant range of motion restrictions, mainly abduction of less than 90 degrees. The clinical notes indicate the patient having completed 15 physical therapy sessions to date. Additionally, the patient is noted to have significant range of motion deficits to include 80 degrees of abduction. Given the patient's previous attempts at conservative therapies and taking into account the significant range of motion deficits in the left shoulder, this request is reasonable. As such, it is the opinion of this reviewer that the request for left shoulder capsular release, left shoulder manipulation under anesthesia is recommended as medically necessary.

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)