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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Apr/11/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Manipulation under anesthesia LT Shoulder / subacromial decompression / debridement / bicep tenodesis / rotator cuff repair

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

Board Certified Orthopedic Surgeon (Joint)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Physical therapy reports 11/11/12 and 12/13/12

Clinical records Dr. 10/18/12-12/27/12

Clinical note PAC 01/14/13 and 03/18/13\

MRI left shoulder 10/24/12

Prior reviews 01/31/13 and 02/27/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx when a beam jerked the patient in the left shoulder. The patient was seen by Dr. on 10/18/12 with complaints of pain in the left shoulder. Physical examination revealed good range of motion in the left shoulder above 90 degrees of forward flexion and abduction. Radiographs were unremarkable and there was concern for a rotator cuff injury. MRI of the left shoulder on 10/24/12 revealed an intact rotator cuff tear with a normal acromioclavicular joint and an intact biceps tendon and labrum.

The patient attended physical therapy through 12/12 with no significant improvement in left shoulder range of motion. The patient was seen on 01/14/13 by PAC. The patient reported continuing pain in the left shoulder despite injections and physical therapy. The patient reported improvement with the use of Vicodin. Physical examination at this visit revealed negative drop arm sign with normal flexion and extension of the left shoulder. There was limited motion with abduction and rotation. The patient was reported to have impingement type symptomology but no specifics were given. The patient was recommended for right shoulder arthroscopy including manipulation under anesthesia. No significant changes were noted on the 03/18/13 clinical record. The request for a left shoulder manipulation under anesthesia with subacromial decompression, rotator cuff, repair biceps tenodesis, and debridement was denied by utilization review on 01/31/13 as there was lack of documentation regarding range of motion deficits that would necessitate manipulation under anesthesia. There was also no indication that the patient had failed continuous physical therapy for at least three months. The request was again denied by utilization review on 02/27/13 as MRI studies were unremarkable and there were no numerical values provided regarding range of motion.

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

The patient has reported ongoing left shoulder pain despite physical therapy and injections. The total amount of physical therapy completed for the patient is very unclear from the clinical records. Additionally, exam findings are limited with no numerical values regarding passive and active measurements in the left shoulder. Imaging study was relatively unremarkable with no evidence of any pathology in the rotator cuff or biceps tendon that would reasonably require any of the requested surgical procedures. Given the lack of any pathology on imaging studies, and given the general generalized reports on physical examination, this reviewer feels that there is insufficient evidence to support any of the surgical requests. As such, it is the opinion of this reviewer that medical necessity of the requested surgeries is not established and the prior denials are upheld.

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)