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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jan/24/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

O/P Right Shoulder MUA

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
Notification of adverse determination dated 01/14/13
Notification of adverse determination dated 01/04/13
Progress notes dated 08/30/12 – 12/20/12
Operative report right shoulder arthroscopy dated 10/23/12
MRI right shoulder dated 05/13/11
Office notes dated 08/12/11 – 12/14/12
Pre-authorization request for physical therapy dated 11/13/12
Initial pain evaluation dated 10/12/12
Operative report right shoulder MUA and arthrogram dated 12/05/11

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who fell at work on xx/xx/xx and injured his right shoulder. MRI dated 05/13/11 revealed a full-thickness tear of the supraspinatus tendon with moderate tendinosis of the supraspinatus and infraspinatus. The claimant underwent right shoulder arthroscopic surgery on 06/24/11 followed by postoperative physical therapy. Manipulation under anesthesia of the right shoulder was performed on 12/05/11. Records indicate that CT arthrogram revealed an acute recurrent tear of the rotator cuff, and the claimant underwent repeat arthroscopic surgery to the right shoulder on 10/23/12 with subacromial decompression and acromioplasty, debridement of superior labral anterior posterior tear, joint synovectomy, removal of adhesions open rotator cuff repair, and microtenotomy of the rotator cuff. Progress note dated 12/20/12 reported that the claimant has finished physical therapy

and still complains of pain, especially with overhead motion. Examination reported active and passive range of motion of the right shoulder and abduction of 0-50 degrees; tender subacromial; tender proximal humerus; 3/5 strength. The patient was recommended to undergo manipulation under anesthesia.

A request for right shoulder manipulation under anesthesia was reviewed on 01/04/13, and the request was determined as not medically necessary as the claimant had not received conservative treatment post-operatively for three to six months.

A reconsideration request for outpatient manipulation under anesthesia of the right shoulder was reviewed on 01/14/13 and the request was non-certified as medically necessary, again noting that the claimant had not received conservative treatment post-operatively for three to six months. It was noted the documents submitted for review indicated that the claimant had only four weeks of physical therapy and it was unclear what other post-operative conservative treatment the claimant had had.

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

The records provided for review reflect that the claimant sustained an injury secondary to a fall, injuring his right shoulder. He underwent right shoulder arthroscopy on 06/24/11. On 12/05/11, the claimant underwent manipulation under anesthesia of the right shoulder. Records indicated that the claimant had recurrent rotator cuff tear and repeat arthroscopic surgery was performed on 10/23/12. It appears that the claimant had approximately four weeks of post-operative physical therapy, with no other conservative measures documented. Official Disability Guidelines provide that manipulation under anesthesia may be considered in cases that are refractor to conservative therapy lasting at least three to six months where range of motion remains significantly restricted with abduction of less than 90 degrees. While it appears that the claimant does have significantly restricted range of motion with abduction to approximately 50 degrees, it does not appear that the claimant has had or that the claimant has or it does not appear that the has failed an appropriate course of conservative therapy lasting at least three to six months. Consequently, the request does not meet Official Disability Guidelines criteria. It is the opinion of this reviewer that medical necessity is not established for the proposed right shoulder manipulation under anesthesia.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES