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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/30/2013

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: M.D., 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. It is the opinion of the reviewer that the request for right shoulder manipulation under anesthesia is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Therapy note 07/30/13
Operative note 05/30/13
Clinical notes 06/11/13
Clinical notes 07/03/13
Clinical notes 08/06/13
Clinical notes 08/20/13
Clinical notes 09/10/13
Previous prior adverse determinations 08/27/13 and 09/17/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who reported an injury to her right shoulder following a comminuted humerus fracture. Operative note dated 05/31/13 indicated the patient undergoing IM rodding of the right humerus. Clinical note dated 06/11/13 indicated the patient presenting for two week follow up regarding IM rodding. The wound was clean and dry. The patient was neurovascularly intact. X-rays revealed satisfactory position of the IM rod. The patient was educated with exercises to do at home. Clinical note dated 07/03/13 indicated the patient having no complaints of pain. The patient was instructed to undergo acromion exercises and to begin moving the elbow. Therapy note dated 07/30/13 indicated the patient initiating post-operative physical therapy. The patient stated that the initial injury occurred when she fell injuring her back and shoulder. Clinical note dated 08/06/13 indicated the patient demonstrating 40 degrees of right shoulder flexion, 50 degrees of abduction, and 85 degrees of internal rotation. Clinical note dated 08/20/13 indicated the patient having problems raising her arm. Subsequent x-rays revealed IM rod to be well placed with a good healing fracture. The patient was recommended for manipulation under anesthesia at this time. Clinical note dated 09/10/13 indicated the patient continuing

with range of motion limitations. The patient initiated a course of physical therapy with no significant improvement. Utilization review dated 08/27/13 resulted in denial for manipulation under anesthesia at the right shoulder secondary to no evidence being submitted regarding failure to respond to conservative treatment lasting at least three months. Utilization review dated 09/17/13 resulted in denial for manipulation under anesthesia as no objective information was submitted confirming failure of conservative treatment.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: Clinical documentation submitted for review notes the patient complaining of right shoulder pain along with range of motion deficits. Manipulation under anesthesia would be indicated at the shoulder provided that the patient meets specific criteria, including failure of a three month course of a three to six month course of conservative treatment. Clinical notes mention previous initiation of physical therapy addressing right shoulder complaints. However, no information was submitted regarding completion of a full three month course of treatment. Additionally, it is unclear if the patient has undergone a home exercise program addressing the right shoulder complaints. Given these findings, this request is not indicated as medically necessary. As such, it is the opinion of the reviewer that the request for right shoulder manipulation under anesthesia is not 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)