



14785 Preston Road, Suite 550 | Dallas, Texas 75254
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DATE OF REVIEW: 5/26/2015

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Manipulation Under Anesthesia left shoulder.

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

M.D. Board Certified in Orthopedic Surgery and Sports Medicine.

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)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with left shoulder injury from a fall on xx/xx/xx. MRI on 9/29/14 showed a full thickness tear of the supra and infraspinatus tendons with retraction as well as some atrophy of the supra and infraspinatus muscles. Surgery was performed 12/4/14 for an open RTC repair, acromioplasty, and distal clavicle resection. Three post op notes are available with the most recent from 2/18/15 at which time an MUA was recommended for failure to progress with range of motion. It is noted that the patient had about a 10 degree improvement in forward flexion in the month from the prior visit to this one. PT notes document 13 visits with the last on 2/18/15. It is documented in this note that there has been measureable improvement in range of motion.

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

Per ODG references, the requested "Manipulation Under Anesthesia left shoulder" is not medically necessary. There is only documentation of about 1 month of PT post operatively and the last documentation available was only 10 weeks post op so the recommended 3-6 months of conservative treatment prior to considering manipulation under anesthesia is not documented. The request for manipulation under anesthesia is therefore not approved.



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

- 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