

Becket Systems

An Independent Review Organization

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DATE NOTICE SENT TO ALL PARTIES: Feb/10/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Outpatient: repeat MUA and Diagnostic A&A Debridement

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, Board Certified Orthopedic Surgery

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 Outpatient: repeat MUA and Diagnostic A&A Debridement is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: Patient is a male. On XX/XX/XX, he was taken to surgery for a left shoulder arthroscopy, debridement of a SLAP lesion, subacromial decompression, distal clavicle resection and rotator cuff repair. On XX/XX/XX, the patient was taken to surgery for a left shoulder manipulation under anesthesia and revision and mini open distal clavicle resection. On XX/XX/XX, the patient was seen back in clinic. It was noted he had been placed at MMI. Examination of his shoulder revealed profound loss of motion in all plains with profound rotator cuff weakness. A repeat diagnostic arthroscopy to assess the status of the rotator cuff repair with repeat manipulation and anesthesia was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On XX/XX/XX, a utilization review letter noted there was no quantitative documentation of range of motion to include abduction less than 90 degrees for a manipulation under anesthesia. There were no submitted imaging studies after the date of the most recent procedure, XX/XXXX. Therefore, the request was non-certified.

On XX/XX/XX, a utilization review determination letter was submitted noting that the clinical findings did not appear to support medical necessity of the requested treatment.

On XX/XX/XX, a peer clinical review report noted the patient had no evidence of post-operative imaging for review, and therefore, the request was non-certified.

The guidelines state that manipulation under anesthesia may be recommended for cases of adhesive capsulitis, refractory to conservative care, where range of motion is significantly reduced with abduction less than 90 degrees. The provider has not indicated a quantitative analysis of range of motion of the patient.

It is the opinion of this reviewer that the request for Outpatient: repeat MUA and Diagnostic A&A Debridement is not medically necessary and 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 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)