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Notice of Independent Review Decision

DATE OF REVIEW: August 7, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

O/P right shoulder manipulation under anesthesia 23700, postoperative physical therapy daily for two weeks, right 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.

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)

I have determined that the requested services are not medically necessary for the treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 7/16/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/18/13.
3. Notice of Assignment of Independent Review Organization dated 7/19/13.
4. Denial documentation.
5. MRI of the right shoulder dated 3/15/12.
6. Medical records dated 9/21/12.
7. Medical records dated 12/18/12.

8. Medical records dated 1/08/13, 1/24/13, 2/19/13, 3/14/13, 4/01/13, 4/29/13, 5/15/13, 6/12/13 and 7/16/13.
9. Medical records dated 3/07/13, 3/28/13, 4/24/13, 5/03/13, 5/31/13 and 6/18/13.
10. Medical records dated 4/29/13.
11. Medical records dated 4/05/13.
12. Document entitled Treatment History.
13. ODG Treatment Integrated Treatment/Disability Duration Guidelines: Shoulder.
14. Letter dated 3/07/13.
15. Letter from the patient dated 7/31/13.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with complaints of shoulder pain. On 3/15/12, an MRI of the right shoulder revealed cystic changes within the posterior promontory of the humeral head suggesting cystic degenerative changes or possibly a cystic Hill-Sachs deformity. There was mild thickening and increased signal intensity within the inferior glenohumeral ligament. The ligament remained intact. There was partial-thickness undersurface tearing of the supraspinatus at its promontory insertion site, but no full-thickness tear or retraction was identified. On 9/21/12, the patient reported continued right shoulder pain rated at 3/10 to 8/10. The provider's assessment was adhesive capsulitis of the right shoulder. On 12/18/12, the patient noted continued right shoulder pain. The patient had not been to physical therapy in a couple of months and developed increasing shoulder pain and reduced range of motion. Per the medical records, range of motion of the shoulder revealed abduction to 45 degrees, internal rotation to S2, and external rotation to approximately 15 degrees. He was able to flex to 90 degrees, and there was no muscle atrophy noted.

On 1/24/13, the documentation noted that the patient had made some significant improvements, including improved range of motion and decreased pain. On 4/05/13, he was seen for physical therapy. The documentation noted active flexion to 148 degrees, and he was able to externally rotate to 70 degrees. On 4/24/13, the documentation noted that an intra-articular injection seemed to help quite a bit. On 4/29/13, the patient reported constant ache to his right shoulder with pain upon certain motions. He was taking ibuprofen for pain relief. He had full abduction with slight anterior deviation of his right shoulder, and he was able to fully anterior flex the right shoulder. He had limited range of motion with both internal and external rotation. On 6/12/13, right shoulder showed limitation of 10 degrees to external rotation at 90 degrees of abduction. He had 45 degrees of restriction to internal rotation on the right. Abduction was limited on the right. The patient has requested coverage for right shoulder manipulation under anesthesia 23700, and postoperative physical therapy daily for two weeks, right shoulder.

The URA indicates that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the initial denial stated that due to the lack of specification of range of motion deficits and improvement with recent conservative care, manipulation of the right shoulder under anesthesia is not justified. On appeal, the URA noted that ODG state that manipulation under anesthesia is under study as an option in adhesive capsulitis. In cases that are refractory to conservative therapy lasting three to six months where range of motion remains significantly restricted (abduction less than 90 degrees), manipulation under anesthesia may be

considered. Per the URA, the clinical evidence does not document range of motion upon abduction less than 90 degrees.

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

The submitted documentation fails to demonstrate the medical necessity of the requested services in this patient's case. On 7/16/13, the medical records noted that the patient can abduct to 70 degrees, and at 70 degrees he starts to compensate with scapular rotation, shoulder elevation, and anterior flexion to achieve greater levels of abduction. On 7/16/13, the records noted that holding the patient's scapula stable and not allowing for rotation allows 70 degrees of abduction passively. This is opposed to the clinical note dated 5/15/13 which noted that the patient can go to 180 degrees with very slight anterior motion. There is discrepancy in the clinical notes as to how much actual motion this patient has. Furthermore, it is also noted that he had improvement in his range of motion with conservative measures. Official Disability Guidelines state that manipulation and anesthesia may be considered reasonable and necessary for those patients who have a diagnosis of adhesive capsulitis that is refractory to conservative measures lasting at least three to six months where range of motion remains significantly restricted with abduction less than 90 degrees. As this has not been objectively demonstrated, the requested O/P right shoulder manipulation under anesthesia 23700, postoperative physical therapy daily for two weeks, right shoulder are not medically necessary.

Therefore, I have determined the requested services are not medically necessary for treatment of the patient's medical condition.

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

- ACOEM- AMERICAN 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 JUDGMENT, 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)