

# Clear Resolutions Inc.

An Independent Review Organization  
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Notice of Independent Review Decision

**DATE OF REVIEW:** SEPTEMBER 9, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Right shoulder arthroscopy with manipulation

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

Board Certified Orthopedic Surgeon

## **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)

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Office note, Dr.

Notes, 02/07/065, 02/28/06, 03/14/06, 04/1/106, 05/16/06 and 03/01/07

Designated Doctor Examination, Dr. 03/23/07

Notification of Determination, 04/25/07

Notification of Determination, 07/23/07

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who underwent right shoulder arthroscopy, rotator cuff repair and distal clavicle excision. He attended physical therapy postoperatively but developed adhesive capsulitis. A Designated Doctor Examination by Dr. on 03/23/07 documented right shoulder range of motion 105 degrees flexion, 90 degrees abduction, 32 degrees extension, 48 degrees adduction, 52 degrees external rotation and 85 degrees internal rotation. The examiner listed diagnoses including right rotator cuff tear post surgical repair, degenerative arthritis of the acromioclavicular joint, Type I SLAP lesion and

adhesive capsulitis. Arthroscopic adhesiolysis followed by physical therapy was recommended.

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

The Reviewer agrees with the determination of the insurance carrier in this case.

The claimant is a male who underwent right shoulder arthroscopy, rotator cuff repair and distal clavicle excision. Postoperatively he developed adhesive capsulitis. He has had some physical therapy but continues with limited range of motion and persistent symptomatology.

This claimant is post-operative and typically would be best managed arthroscopically with lysis of adhesions; however there is no evidence that this claimant went on to heal the rotator cuff. Therefore, the above procedure might not be appropriate and reasonable given the fact that 25 percent do not go on to heal. There is no documentation about repair strength or integrity of the repair following surgery. Based on a careful review of all medical records there is not enough information to support right shoulder arthroscopy with manipulation as being medically necessary following a rotator cuff repair.

Hypothetically, if the rotator cuff has clinical evidence of healing, then certainly arthroscopy would be favorable over manipulation as there are postoperative adhesions to protect the repair. To do a lysis of the subacromial adhesions and capsular release has been shown to be more efficacious as opposed to manipulation alone.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates: Shoulder "Manipulation Under Anesthesia (MUA): MUA may be recommended as an option in primary frozen shoulder to restore early range of movement and to improve early function in this often protracted and frustrating 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 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)