

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

DATE OF REVIEW: SEPTEMBER 18, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Shoulder arthroscopy surgery; treat shoulder dislocation

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 notes, Dr. 1/15/06, 12/29/06, 02/05/07, 03/12/07, 04/06/07, 04/10/07, 04/20/07, 05/14/07, 06/08/07, 07/09/07 and 07/23/07

Left shoulder MRI, 12/20/06

Operative report, Dr., 01/30/07

Physical therapy notes, 04/18/07, 05/11/07, 05/23/07 and 06/06/07

Peer reviews, 06/15/07, 07/05/07 and 08/14/07

Functional capacity evaluation, 07/19/07

Letter, Dr., 08/03/07

No ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old mechanic who underwent a 01/30/07 open rotator cuff repair, subacromial decompression and extensive debridement of a labral tear on 01/30/07. Postoperatively, the claimant progressed slowly with physical therapy. On 04/20/07, Dr. documented range of motion as 130 degrees of flexion, 115 degrees of abduction, external rotation to 30 degrees and internal rotation was to his back pocket. On 06/08/07, Dr. noted the claimant lacked 20 degrees of flexion and 30 degrees of abduction. The office note on 07/09/07 documented 140 degrees of flexion and 35

degrees of external rotation. A 07/19/07 functional capacity evaluation documented the claimant could perform at light duty but not at his required level of heavy duty. Dr. authored a letter on 08/03/07 documenting that the claimant had plateaued in physical therapy and that the functional capacity evaluation documented 100 degrees of flexion, 50 degrees of extension, 94 degrees of abduction and 30 degrees of adduction, 60 degrees of external rotation and 38 degrees of internal rotation. Dr. has recommended a manipulation with arthroscopic debridement and possible capsular release.

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

The diagnosis for this claimant is status post open rotator cuff subacromial decompression and debridement 01/30/07. There were no intra-operative or post-operative complications noted. He was treated with rehab with therapy, off work and Norco. He made good progress in February, March and April noting some tightness throughout the arc of motion April 6, 2007. Dr. felt on June 8, 2007 he was lacking terminal flexion 30 degrees of abduction and he recommended manipulation, possible arthroscopic debridement, capsular release.

The request for manipulation falls outside the standard guidelines for Texas, specifically significant restricted range of motion, abduction less than 90 degrees lasting greater than six months. In addition there is no documentation of an attempt to relieve some of the symptomatology with either an anti-inflammatory course, Medrol-Dosepak, or to consider cortisone injection either glenohumeral or subacromial space. Based on the lack of conservative treatment and the failure to meet recommended guidelines the request cannot be recommended as reasonable, necessary or medically appropriate at this juncture.

Official Disability Guidelines Treatment in Workers' Comp 2007 Updates, Shoulder

Recommended as indicated below. **Criteria** for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear.

Under study as an option in adhesive capsulitis. In cases that are refractory to conservative therapy lasting at least 3-6 months where range-of-motion remains significantly restricted (abduction less than 90°), manipulation under anesthesia may be considered. There is some support for manipulation under anesthesia in adhesive capsulitis, based on consistent positive results from multiple studies, although these studies are not high quality. (Colorado, 1998) (Kivimaki, 2001) (Hamdan, 2003) Manipulation under anesthesia (MUA) for frozen shoulder may be an effective way of shortening the course of this apparently self-limiting disease and should be considered when conservative treatment has failed. 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. (Andersen, 1998) (Dodenhoff, 2000) (Cohen, 2000) (Othman, 2002) (Castellarin, 2004) Even though manipulation under anesthesia is effective in terms of joint mobilization, the method can cause

iatrogenic intraarticular damage. (Loew, 2005) When performed by chiropractors, manipulation under anesthesia may not be allowed under a state's Medical Practice Act, since the regulations typically do not authorize a chiropractor to administer anesthesia and prohibit the use of any drug or medicine in the practice of chiropractic. (Sams, 2005) See also the Low Back Chapter, where MUA is not recommended in the absence of vertebral fracture or dislocation.

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)