

I-Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jul/07/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Shoulder Arthroscopy Adhesiolysis

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., 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

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Shoulder: Surgery for adhesive capsulitis

MRI right shoulder, 04/28/10

Office note, Dr., 05/03/10, 4/21/10, 03/08/10, 02/04/10, 01/13/10, 12/23/09

Pre-authorization request, 05/04/10

Zurich Services Corporation, 5/10/10, 5/25/10

attorney, 6/30/10

MD, 4/30/10

Operative Report, 1/26/10

PT Treatment Notes, November 2009-March 2010

PATIENT CLINICAL HISTORY SUMMARY

This is a male claimant diagnosed with right shoulder subacromial adhesions status post arthroscopy, acromioplasty, coplanar AC (acromioclavicular) arthroplasty and superior labral repair on 09/30/09. This was followed by a manipulation under anesthesia on 01/26/10. A physician record dated 05/03/10 noted the claimant with continued discomfort diffusely over the cap of the right shoulder. Review of a right shoulder MRI performed on 04/28/10 showed chronic longitudinal splitting of the tendon and the long head of the biceps. There was a subtle degree of irregularity of the posterior labrum and the undersurface of the supraspinatus compatible with his prior surgery. Subacromial adhesions were diagnosed. An injection was given and an arthroscopic adhesiolysis recommended.

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

This request is for right shoulder arthroscopic adhesiolysis. A note was reviewed of Dr. dated 05/03/10. The claimant has undergone a previous right shoulder arthroscopy and PASTA lesion repair. A labral repair was also performed. He has had extensive therapy. He underwent a manipulation on 01/26/10. Range of motion, however, was noted to be good when seen 05/03/10 by Dr.. He underwent an injection. The rationale for the procedure is not adequately expressed in the information provided. Range of motion does not appear to

be limited. Requirement for an arthroscopic lysis of adhesions is poorly outlined in the information reviewed. His range of motion was not documented. One would proceed with lysis of adhesions for adhesive capsulitis. Adhesive capsulitis would cause restricted range of motion and in the absence of that finding, the surgical intervention of arthroscopic adhesiolysis would not be medically necessary. The reviewer finds that medical necessity does not exist at this time for Right Shoulder Arthroscopy Adhesiolysis.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Shoulder: Surgery for adhesive capsulitis

Under study. The clinical course of this condition is considered self-limiting, and conservative treatment (physical therapy and NSAIDs) is a good long-term treatment regimen for adhesive capsulitis, but there is some evidence to support arthroscopic release of adhesions for cases failing conservative treatment. (Dudkiewicz, 2004) (Guler-Uysal, 2004) (Castellarin, 2004) (Berghs, 2004) Study results support the use of physical therapy and injections for patients with adhesive capsulitis. (Pajareya, 2004) (Carette, 2003) (Arslan, 2001)

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)