

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** May/20/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** OP right shoulder scope, capsular release & manipulation

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., 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 medical necessity for OP right shoulder scope, capsular release & manipulation in this case has not been established.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who sustained an injury on xx/xx/xx. The patient was status post right shoulder arthroscopy including arthroscopic rotator cuff repair, labral repair, subacromial decompression, distal clavicle excision, and biceps tenodesis on 10/10/13. The patient was evaluated on 01/16/14 with continuing complaints of pain that was mild in the right shoulder. On physical examination range of motion of the right shoulder was not specifically assessed. The patient was reported to making progress with physical therapy; however, range of motion was restricted. The patient was recommended for a Depomedrol injection for adhesive capsulitis at this evaluation. Follow up on 02/11/14 again noted that the patient had difficulty with range of motion regards to the right shoulder. On physical examination active elevation was limited to 90 degrees with passive elevation to 120 degrees. External rotation was limited to 10 degrees actively and passively to 20 degrees. Internal rotation was to L5. No weakness was apparent. The patient received a Depomedrol injection at this visit. Follow up with FNP on 03/12/14 indicated the patient had been performing daily physical therapy activities but continued to have limited range of motion in the right shoulder. On physical examination elevation was limited to 115 degrees actively with 10 degrees external rotation and internal rotation to L4. Passive elevation was to 130 degrees and passive external rotation was to 35 degrees. Given the limited range of motion the patient was recommended for manipulation and arthroscopic capsular release. This procedure was denied by utilization review on 03/21/14 that there was abduction of less than 90 degrees or what improvement had been made with physical therapy. The request was again denied by utilization review on 04/11/14 as it was unclear what abduction measurements were present and there was limited evidence supporting the efficacy of capsular relief and manipulation under anesthesia in patients with adhesive capsulitis.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has continuing persistent loss of range of motion in the right shoulder following arthroscopic rotator cuff repair with associated subacromial decompression distal clavicle excision and labral repair in October of 2013. The extent of physical therapy was not available for review. It is actually unclear to what extent the patient has attended physical therapy to date or what the results from physical therapy were. It was unclear whether the patient reached a reasonable plateau with ongoing physical therapy. Additional clinical documentation submitted for review did not address the concerns of the prior reviewer regarding the measurement of abduction in the right shoulder. It is currently unclear whether there was loss of abduction below 90 degrees both passively and actively to support capsular release arthroscopically and manipulation under anesthesia. As the concerns of the prior reviewer were not addressed and there was minimal clinical documentation regarding the actual physical therapy program provided to this patient, it is the opinion of this reviewer that medical necessity for OP right shoulder scope, capsular release & manipulation in this case has not been established. As such the 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)