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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 12/09/2010

IRO CASE #:

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

This case was reviewed by an Orthopaedic Surgeon, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Manipulation under anesthesia and arthrocentesis (aspiration) and steroid injection, left shoulder

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 08-17-09 MR arthrogram left shoulder read by Dr.
- o 09-16-09 Electro-Diagnostic Interpretation from Dr.
- o 09-23-09 Orthopedic follow-up report
- o 07-12-10 Patient Reevaluation report from Dr., DC
- o 07-14-10 Patient referral for cortisone injections from Dr.
- o 08-02-10 Initial orthopedic report from Dr.
- o 08-02-10 ROM - Inclination of the shoulder, unsigned
- o 08-11-10 MR arthrogram left shoulder read by Dr.
- o 08-18-10 Follow-up orthopedic report from Dr.
- o 08-23-10 EMG studies upper extremity interpreted by Dr..
- o 09-30-10 FCE from, signature illegible
- o 10-04-10 Follow-up orthopedic report from Dr.
- o 10-13-10 Initial Adverse Determination review
- o 11-08-10 Adverse Determination review on reconsideration
- o 0x-03-10 Fax cover appeal from unsigned
- o 11-19-10 Request for IRO from the Claimant
- o 11-19-10 Confirmation of Receipt of Request for IRO from TDI
- o 11-22-10 Notice to P&S of Case Assignment from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a male who sustained an industrial injury to the left shoulder on xx/xx/xx when he fell onto his outstretched hand. Left shoulder MR Arthrogram of August 17, 2009 showed a full thickness rotator cuff tear and a small modest place tear of the anterior labrum with Hill-Sachs deformity with adjacent bone marrow edema in the humeral head. A transient subluxation/dislocation was suspected. The patient underwent left shoulder Bankart repair, subacromial decompression with rotator cuff repair on September 18, 2009 and has attended 20 sessions of work hardening, 10 sessions of work conditioning and 24 sessions of PT. He has also attended a chronic pain management program.

Electrodiagnostic studies of September 15, 2009 showed evidence of chronic left C4-5 cervical radiculopathy and mild right carpal tunnel syndrome.

Orthopedic follow-up report dated September 23, 2009 indicates the patient is doing well post-op and PT is ordered with instructions of no active external rotation or abduction for 6 weeks.

The patient was reevaluated by his chiropractic provider on July 12, 2010 for persisting left shoulder pain. He saw an orthopedic specialist who determined he had a torn rotator cuff. After surgery, he attended rehabilitation and 10 sessions of work conditioning. He was noted to have a fear of lifting and re-injury. He has been referred for work hardening, which has finally been approved. He underwent a physical performance evaluation on April 22, 2010. He continues to show weakness and restriction in the left shoulder and moderate guarding when performing box-lifting exercises. He is concerned and frustrated about the restricted ROM as well as his ongoing pain levels in the left shoulder. Speed's test and Apley's test are positive. Supraspinatus strength is weak on the left compared to right. Flexion on the left is to 150 degrees. Extension is to 39 degree, abduction to 148 degrees and adduction to 41 degrees. Recommendation is for an orthopedic evaluation to consider a cortisone injection.

The patient was referred for cortisone injection to the left shoulder on July 14, 2010.

Orthopedic evaluation of August 2, 2010 noted left shoulder pain of 5/5 with popping, stiffness, clicking, locking, neck pain, weakness, limited rotation and difficulty sleeping. He has not been improved with NSAIDS or PT. "He has had cortisone injections to the shoulder, but he was in so much pain that he doesn't think it helped." Active left shoulder extension is to 40 degrees, flexion to 155 degrees. Passive abduction is to 90 degrees. He has no active external rotation. Impingement sign is positive. X-rays taken this visit show normal bone density. "Significant loss of motion mainly to flexion and external rotation suggests over tightening of anterior-inferior glenohumeral ligament." MR arthrogram and repeat nerve studies (to include the suprascapular nerve) were recommended.

MR arthrogram performed August 11, 2010 was given impression: Postoperative changes consistent with prior rotator cuff repair without recurrent partial or full-thickness tear identified. 2. Changes consistent with a chronic Hill-Sachs deformity and prior Bankart repair without significant recurrent labral tear. There is some minimal grade II chondromalacia along the anterior inferior aspect of the bony glenoid, which is likely related to suture anchor placement and not any recurrent new chondral defect. 3. Trace amount of fluid/bursitis within the subacromial/subdeltoid bursa without significant impingement from the AC joint. No subacromial spurring. 4. Otherwise, left shoulder MR arthrogram within normal limits as described above.

Orthopedic follow-up of August 18, 2010 noted pain level of 5/10. He is 6 feet and 255 pounds. He has a well-healed surgical incision. Active and passive extension are to 25 degrees. Active flexion is 110 degrees and passive 165 degrees. Active abduction is to 75 degrees and passive 85 degrees. External rotation is to 75 degrees actively and to 85 degrees passively. Left motor strength is weak at the deltoid and supraspinatus (4/5). Imaging shows the repair is intact, bursitis and AC inflammation. Diagnosis is brachial neuritis, joint stiffness, adhesive capsulitis and synovitis. He continues to have rotator cuff dysfunction of his supra and infraspinatus. He has stiffness to external rotation from his capsular repair. Recommendation is for MUA as he has failed for the capsular stiffness.

Upper extremity nerve studies performed August 23, 2010 showed moderate right carpal tunnel syndrome and no definite electromyographic evidence of any additional neuropathic process.

The patient was tested on September 30, 2010 to determine his physical performance capacity. He reports constant achy pain at the left shoulder. He has had x-rays, MRIs, nerve studies, left shoulder surgery and PT. He reports occasional numbness in the palmar side of the left thumb. He is a and his job demand a Very-Heavy PDL. His overall effort was determined to be reliable. He reports pain of 5/10 at the left shoulder. Left shoulder strength is weaker than right. Testing showed he is unable to perform at his required PDL. He is currently at a Medium PDL (can lift 40 pounds). Computerized ROM showed the following: Internal rotation is 45/75, external rotation 34/55, flexion 123/175, extension 30/45, adduction 29/33 and abduction 123/165. Comparison with left shoulder ROM demonstrated on August 6, 2010 there has been a decrease in internal rotation of 21% and extension of 14%.

The patient was reevaluated orthopedically on October 4, 2010. He has shoulder pain of 5/10 without movement that can increase to 10/10 with activities. He has benefited from NSAIDS and PT. Active and passive extension on the left are to 25 degrees. Abduction is 75 actively and 85 passively. Active and passive external rotation is to 10 degrees. Motor strength shows 4/5 at the left deltoid and supraspinatus and external rotation. Following surgery in September 2009 he completed 20 work hardening sessions, 10 sessions of work conditioning and 24 PT sessions with minimal improvement in pain and ROM. He also completed a pain management program. PPE of September 30, 2010 showed restricted ROM and weakness of the left shoulder compared to the right. He is unable to return to work safely at this time. Passive abduction remains less than 90 degrees along with 10 degrees of external rotation. He has failed 3-6 months of conservative treatment consisting of PT, NSAIDS, pain management and work conditioning programs. Recommendation is for MUA with steroid injection of major joint/bursa followed by 4-6 weeks of PT.

Examination of October 7, 2010 notes active and passive extension of 25 degrees, active flexion of 110 degrees and passive flexion of 165 degrees, active abduction of 75 degrees and passive of 85 degrees and 10 degrees of active and passive external rotation. The patient is using NSAIDs unspecified, Vicodin and Lodine.

Request for manipulation under anesthesia and arthrocentesis and steroid injection, left shoulder was considered in review on October 13, 2010 with recommendation for non-certification. A peer discussion was attempted but not realized. According to the reviewer, the patient is status post left shoulder Bankart repair, subacromial decompression with rotator cuff repair on September 18, 2009 and has attended 20 sessions of work hardening, 10 sessions of work conditioning and 24 sessions of PT. He has attended a chronic pain management program. Examination of October 7, 2010 notes active and passive extension of 25 degrees, active flexion of 110 degrees and passive flexion of 165 degrees, active abduction of 75 degrees and passive of 85 degrees and 10 degrees of active and passive external rotation. The patient is using NSAIDS unspecified, and Vicodin and Lodine. At a later time, there was a discussion with a PA who was unable to provide additional clinical information to support the request. It is not clear why work hardening and work conditioning were provided for post adhesive capsulitis. It has been one year since the surgery and it is not clear that MUA would be useful this long after a surgery. Per ODG MUA is under study as an option for adhesive capsulitis. In cases that are refractory to conservative therapy lasting at least 3-6 months where ROM remains significantly restricted (abduction less than 90 degrees), MUA may be considered. There is some support for MUA in adhesive capsulitis, based on consistent positive results from multiple studies, although these studies are not high quality. For adhesive capsulitis, injection of corticosteroid combined with a simple home exercise program is effective in improving shoulder pain and disability. Adding PT provides faster improvement in shoulder ROM.

Request for reconsideration manipulation under anesthesia and arthrocentesis and steroid injection, left shoulder was considered in review on November 8, 2010 with recommendation for non-certification. A peer discussion was attempted but not realized. The patient was training. He underwent left rotator cuff repair and labral repair in September 2009. He has had extensive post-op PT as well as a pain management program, work hardening and work conditioning. Examination of October 4, 2010 notes pain of 5/10, continued popping and locking with numbness. Left shoulder ROM notes active/passive 110/165, abduction 75/85, external rotation 10/10, extension 25/25, internal rotation with extension right and left to L1, external rotation with arm abducted to 90 degrees. Sensation is normal and motor strength deficient at 4/5. No instability has been found. The patient has not had a cortisone injection prior to the request for MUA.

Request was made for an IRO.

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

ODG: MUA is 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.

First level denial rationale questions the usefulness of MUA one year after a surgery. Second line denial rationale simply notes the patient has not had a cortisone injection prior to the request for MUA. Orthopedic report of August 2, 2010 indicates he has had cortisone injections to the shoulder, but he was in so much pain that he doesn't think it helped. A close reading of the submitted reports indicates that the patient was a candidate for MUA in approximately August 2010. However, the patient is now 14 months post surgery and ODG indicates that MUA is useful to restore "early range of movement" and to improve "early function" in this often protracted and frustrating condition. Given the duration since the surgery, MUA is not the best plan at this time. Additionally, given the continued popping and locking with numbness noted on October 4, 2010, additional surgery may be a consideration.

Therefore, my recommendation is to agree with the previous non-certification for manipulation under anesthesia and arthrocentesis (aspiration) and steroid injection, left shoulder.

The IRO's decision is consistent with the following guidelines:

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 KNOWLEDGBASE

____ 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

The Official Disability Guidelines 11-08-2010 Shoulder Chapter - Manipulation under anesthesia (MUA):

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.

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.

Even though manipulation under anesthesia is effective in terms of joint mobilization, the method can cause iatrogenic intraarticular damage.

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.

This case series concluded that MUA combined with early physical therapy alleviates pain and facilitates recovery of function in patients with frozen shoulder syndrome. (Ng, 2009) This study concluded that manipulation under anaesthesia is a very simple and noninvasive procedure for shortening the course of frozen shoulder, an apparently self-limiting disease, and can improve shoulder function and symptoms within a short period of time, but there was less improvement in post-surgery frozen shoulders. (Wang, 2007) See also the Low Back Chapter, where MUA is not recommended in the absence of vertebral fracture or dislocation.