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Notice of Independent Review Decision

DATE OF REVIEW: 06/18/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Right Shoulder Arthroscopy With Lysis Of Adhesions With Manipulation

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

Texas Board Certified Orthopedic Surgeon
Texas Board Certified Orthopedic Sports Medicine

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 11/18/09 through 01/11/10, Initial evaluation, Dr.
2. 11/23/09, MRI of the right shoulder
3. 01/08/10, Operative report
4. 02/03/10, Postoperative follow up with Dr.
5. 02/04/10, Physical therapy evaluation
6. 02/08/10 through 02/22/10, Physical therapy progress notes
7. 02/16/10 and 04/06/10, Clinical notes, Dr.
8. 05/03/10 and 05/06/10, Physical therapy progress notes
9. 05/06/10 and 05/18/10, Clinical note, Dr.
10. 05/26/10, Physical therapy progress note
11. 05/17/10, MRI of the right shoulder
12. 05/25/10 and 06/02/10, Utilization review reports
13. 06/03/10, Progress note, Dr.
14. 01/14/10 through 05/28/10, Prescription refill requests
15. 02/08/10 through 05/05/10 Texas Workers' Compensation status reports
16. Coversheet and working documents
17. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who stated that he was rolling a hose off a semi truck when he was injured. The employee "yanked" his entire right shoulder down causing immediate swelling and pain. It appeared the employee did have initial radiographs; however, no

reports were submitted for review. The employee was stated to have undergone Cortisone injections in August or September that improved the employee's pain. The employee stated that he returned back to work and appeared to do well.

In October, the employee stated that he tripped and tried to catch himself, which caused a return of pain in the right shoulder. Medication at this visit included Darvocet N-100. Physical examination revealed tenderness over the anterior glenohumeral joint and acromioclavicular joint of the right shoulder. Restricted range of motion actively and passively was present and crepitus was noted. Positive impingement signs were seen. There was weakness noted with external rotation and abduction. Positive Tinel's sign was noted at the elbow. The employee was assessed with a possible labral tear and ulnar neuritis.

An MRI of the right shoulder was recommended and performed on 11/23/09. This study demonstrated a superior labral tear both anteriorly and posteriorly at the glenoid labrum. The biceps tendon did not appear to be involved, and there were moderate osteoarthritic changes in the acromioclavicular joint.

The employee followed up with Dr. on 11/30/09 for an MRI review. Dr. recommended subacromial decompression and SLAP lesion repair to the right shoulder. Physical examination was unchanged.

The employee underwent arthroscopic debridement and repair of the right shoulder SLAP lesion with acromioplasty and distal claviclectomy on 01/08/10. The employee had no postoperative complications and was recommended to begin physical therapy on 02/03/10.

Initial physical therapy evaluation on 02/04/10 reported reduced range of motion of the right shoulder on adduction examination, most significantly on flexion and abduction. Both active and passive ranges of motion were significantly restricted. Gross strength was markedly reduced and specific muscle testing was deferred. The employee was recommended to begin physical therapy to improve range of motion and strength.

Follow up with Dr. on 03/16/10 stated the employee had not recently been to physical therapy due to blood pressure problems. The employee reported lightheadedness and shortness of breath with physical therapy. The employee stated that he had been compliant with home exercises but continued to complain of weakness in the shoulder with popping. Physical examination revealed near full passive and active range of motion of the right shoulder. Negative impingement signs were present. The employee continued to have weakness throughout the right shoulder. The employee was recommended to restart physical therapy as soon as his blood pressure problems were controlled.

The employee returned to Dr. on 04/06/10 with continued problems in the right shoulder. The employee reported constant mild pain and popping. The employee stated that he was compliant with home exercises, but he had not started active therapy at that point in time. Physical examination revealed some restriction and external rotation at 40 degrees in the right shoulder. No popping was noted. Impingement signs were negative and the employee continued to have weakness in the right shoulder.

The employee restarted active physical therapy on 05/03/10.

Follow up with Dr. on 05/06/10 stated the employee had continuing pain in the shoulder with range of motion despite therapy. The employee also had no improvement with shoulder strength. Physical examination revealed tenderness to the right side of the acromioclavicular joint in the right shoulder. Restriction of external rotation continued and popping was noted within the shoulder joint during range of motion, which was undefining. Negative impingement sign was present, and the employee continued to have weakness. The employee was recommended for a repeat MRI of the right shoulder.

The MRI study, which was performed on 05/17/10, revealed a previous SLAP repair and acromioplasty. Fluid collection was present at the acromioplasty site raising a question of a cyst.

Follow up with Dr. on 05/18/10 stated the employee was requesting a steroid injection. The employee continued to complain of popping sensations in the shoulder. Physical examination revealed some passive range of motion restriction on abduction with popping noted within the shoulder joint. The employee was recommended for arthroscopic lysis of adhesions with manipulation. It appeared the employee was discharged from physical therapy due to noncompliance. The employee's last physical therapy visit was 05/03/10.

The request for surgery for lysis of adhesions was not recommended as medically necessary by utilization review on 05/25/10. Dr. opined that surgery was not recommended as the employee had "near full range of motion", and there was lack of evidence of recent aggressive physical therapy, which would have reasonably improved the employee's condition. The request for surgery to include arthroscopic lysis of adhesions and manipulation was again denied via utilization review, as the employee had full range of motion of the right shoulder with no MRI evidence of adhesions.

Follow up with Dr. on 06/03/10 stated the employee did have a decrease in shoulder pain with a recent infection. The employee continued to have popping and weakness with decreased range of motion in the shoulder. Physical examination revealed restricted range of motion in the shoulder with limited flexion to 130 degrees and abduction limited to 85 degrees.

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

The clinical documentation submitted for review does not support the request for surgery to include lysis of adhesions or manipulation under anesthesia. The MRI study submitted for review failed to reveal any significant adhesions present in the right shoulder that would reasonably be improved with the requested procedure. Per ***Official Disability Guidelines***, manipulation under anesthesia for the shoulder is not recommended without evidence of plateauing during physical therapy. There also should be evidence of adhesions on MRI studies warranting surgery to debride adhesions. As the clinical documentation presented for review does not support the requested procedures.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

Official Disability Guidelines, Shoulder Chapter, online version.

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](#)) 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.