

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 12, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed right shoulder MUA (23700, 20610)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
726.0	23700, 20610		Prosp	1			11.27.2008	C8284771	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-15 pages

Respondent records- a total of 382 pages of records received to include but not limited to:

xxxxx letter 4.26.10; Request for an IRO forms; xxxxx letter 3.31.10, 4.16.10; xxxxx report 7.9.09; xxxxx report 4.26.10; DWC forms1, 73; Ar xxxxx letter 12.30.08, 2.24.10; xxxxx sheet 11.27.08; xxxxx notes 11.28.08-11.29.08; lab report; xxxxx12.3.08-12.9.08; xxxxx records 12.17.08-4.5.10; xxxxx1.6.09-2.3.09; MRI Rt Shoulder 1.7.09; x-ray rt shoulder; xxxxx 2.16.09-1.20.10; xxxxx notes 2.16.09-1.20.10; xxxxx 9.30.09; report 12.23.09-1.29.10; WCE 1.12.10; xxxxx 1.12.10; Ed, LPC 1.12.10; TDI letter 1.5.10; report Dr. 1.19.10; xxxxx 2.1.10-3.23.10

Requestor records- a total of 68 pages of records received to include but not limited to: TDI letter 4.22.10, 6.19.09; Records ; xxxxx 2.16.09-1.20.10; Lone Star Orthopedics notes 2.16.09-1.20.10; MRI Rt Shoulder 1.7.09; xxxxx letters 3.31.10, 12.2.09, 6.8.09, 5.29.09; xxxxx9.23.09-9.30.09; xxxxx report 7.9.09

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with a may 29, 2009 request for shoulder surgery with subacromial decompression. This request was not certified. One week later, a reconsideration was submitted and the non-certification was upheld.

The surgery was completed on September 30, 2009. An IRO opinion was sought and endorsed the surgery. The surgery included a subacromial decompression a debridement of the partial rotator cuff tear and other issues.

In December, there was request for a manipulation under anesthesia for the right shoulder. This was also not certified. A reconsideration of this a surgical request was also upheld and not certified.

A 3-D right shoulder MRI was completed on January 7, 2009. The study identified supraspinatus and ever status tendinosis. Some impingement of the supraspinatus was noted as well. A functional capacity evaluation was also completed.

The first orthopedic consultation was completed on February 16, 2009. The impingement syndrome and rotator cuff tendinitis was identified. Conservative care continued and ultimately the surgical procedure was completed. In the initial post operative phase, the injured employee did reasonably well. Subsequent to the date of surgery. The range of motion increased markedly. Initial abduction was 30 and currently is nearly 5 times that amount.

January 20, 2010 an orthopedic progress note from Dr. identified the date of injury as being November 27, 2008. It is noted that the post operative physical therapy was actually chiropractic intervention. At the request of the chiropractor, a manipulation under anesthesia was sought. There was no clear clinical indication for this procedure, and certification was not presented initially or any reconsideration protocol.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines, 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. 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](#)) Even though manipulation under anesthesia is effective in terms of joint mobilization, the method can cause iatrogenic intraarticular damage. ([Loew, 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 anesthesia 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](#))

When noting the standards listed above. There is no adhesive capsulitis when there is flexion of 140°. There is no frozen shoulder and accordingly this procedure is not warranted.

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
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)