

INDEPENDENT REVIEWERS OF TEXAS, INC.

4100 West Eldorado Pkwy' Suite 100 -373 . McKinney, Texas 75070

Office 469-218-1010 . Toll Free Fax 469-374-6852 e-mail: independentreviewers@hotmail.com

Notice of Independent Review Decision

[Date notice sent to all parties]:

08/05/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Medical necessity of Left shoulder MUA and left hand MUA all digits 23700 26340?

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

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Electrodiagnostic studies dated 01/10/13
Therapy notes dated 04/16/13
Clinical notes dated 11/28/12 – 05/28/13
Utilization review dated 06/13/13, 06/27/13
Diagnostic Ultrasounds dated 01/24/13
Operative report dated 03/27/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury to his left upper extremity. Clinical note dated 11/28/12 detailed the patient complaining of left wrist and shoulder pain. The patient

utilized naproxen and Norco for ongoing pain relief. Electrodiagnostic studies on 01/10/13 revealed no evidence of either a neuropathy or radiculopathy. Diagnostic ultrasound on 01/10/13 revealed essentially normal findings at both the left and right trapezius. Clinical note dated 02/11/13 detailed the patient rating his shoulder pain as 4/10. The patient underwent physical therapy at that time. Upon exam pain was elicited upon palpation at the left shoulder. The patient was unable to make a fist with the left hand. Operative report dated 03/27/13 detailed the patient undergoing left shoulder arthroscopic labral debridement and rotator cuff repair and acromioplasty. Clinical note dated 03/05/13 detailed the past medical history as significant for a fracture of the left forearm. The patient previously underwent physical therapy and non-steroidal medications. Clinical note dated 04/11/13 detailed the patient continuing with left shoulder pain despite previous surgical procedure. The patient was recommended for physical therapy at that time. Therapy note dated 04/16/13 detailed the patient being assessed for physical therapy. The patient demonstrated 85 degrees of left shoulder flexion, 20 degrees of abduction, extension, and internal rotation, and -10 degrees of external rotation. Strength deficits were noted throughout the left shoulder. Clinical note dated 04/30/13 detailed the patient utilizing anti-inflammatory cream on hand and shoulders. Clinical note dated 05/28/13 detailed the patient lacking full range of motion at the hand and shoulder. Previous utilization review dated 06/13/13 for the manipulation under anesthesia at the shoulder and left hand resulted in denial as no information was submitted regarding response to a full course of three to six months of conservative treatment. Additionally, range of motion restrictions did not meet the necessary criteria to indicate adhesive capsulitis at the shoulder. Additionally, no high quality studies existed supporting manipulation under anesthesia at the hands and wrists. Previous utilization review dated 06/21/13 resulted in denial for manipulation under anesthesia at the shoulder and hand as no information was submitted confirming completion of a full three to six month course of conservative treatment. Additionally, left shoulder adduction and abduction were 95 degrees whereas guidelines recommended restrictions of greater than or less than 90 degrees.

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

The request for clinical documentation submitted for review notes the patient complaining of ongoing left shoulder pain despite previous surgical intervention. Left shoulder manipulation under anesthesia would be indicated provided that the patient meets specific criteria, including completion of all conservative measures including physical therapy for greater than three months and significant range of motion deficits throughout the left shoulder. Clinical notes mention previous therapy evaluation. However it is unclear if the patient completed a full course of treatment addressing the left shoulder complaints. Given that no information was submitted regarding completion of a three month course of physical therapy addressing the left shoulder complaints this request does not meet guideline recommendations.

Additionally, no information and no current high quality studies exist supporting the safety and efficacy of manipulation under anesthesia at the hands. Given this the request is not indicated as medically necessary. As such it is the opinion of this reviewer that the request for left shoulder and hand manipulation under anesthesia with all digits is not indicated.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

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. (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) Two lower quality studies have recently provided some support for the procedure. In this study manipulation under suprascapular nerve block and intra-articular local anesthesia shortened the course of frozen shoulder (FS), although it is an apparently self-limiting disease. (Khan, 2009) In this study manipulation under anesthesia combined with arthroscopy was effective for primary frozen shoulder. (Sun, 2011) Frozen shoulder has a greater incidence, more severe course, and resistance to treatment in patients with diabetes mellitus compared with the general population, but outcomes for diabetic patients with frozen shoulder undergoing treatment with manipulation under general anaesthesia (MUA) are the same as patients without diabetes. (Jenkins, 2012) In this case series, treatment of frozen shoulder by MUA led to improvement in shoulder motion and function at a mean 23 years after the procedure. (Vastamäki, 2012) The latest UK Health Technology Assessment on management of frozen shoulder concludes that there was very little evidence available for MUA and most of the studies identified had limitations. The single adequate study found no evidence of benefit of MUA over home exercise alone. Generalizability is somewhat unclear because of the limited

information about previous interventions that participants had received and stage of frozen shoulder. (Maund, 2012) The fastest improvement occurs following the first month after MUA, but 6 months after MUA, shoulder active range of motion remains lower than the uninvolved extremity. (Sokk, 2012) See also the Low Back Chapter, where MUA is not recommended in the absence of vertebral fracture or dislocation.

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

Gevirtz, Clifford MD, MPH. Topics in Pain Management: Manipulation Under Anesthesia: The Pain Management Perspective. May 2011 - Volume 26 - Issue 10 - p 1–6

ST Canale, JH Beaty Campbell's Operative Orthopaedics: Hand Surgery- 2012.