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Notice of Independent Review Decision

Date notice sent to all parties:

February 5, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Appeal outpatient left shoulder manipulation under anesthesia 23700

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

Board Certified Orthopedic Surgeon (Joint)

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:

Clinical notes dated 11/14/11 – 11/22/11
MRI left shoulder dated 11/17/11
Orthopedic consult dated 01/05/12
Clinical notes dated 01/31/12
Clinical note of dated 04/16/12

Radiographs left shoulder dated 04/16/12
Designated doctor's evaluation dated 07/03/12
Clinical report from dated 08/22/12
Clinical notes from Physicians of dated 09/05/12 – 10/05/12
Radiographs left shoulder dated 09/06/12
Prior reviews dated 11/26/12 and 12/27/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx while at work. The patient reported persistent left shoulder pain. Initial MRI studies of the left shoulder completed on 11/17/11 revealed a large full-thickness rotator cuff tear involving both the supraspinatus and infraspinatus tendons. There was subluxation of the humeral head superiorly relative to the glenoid with no space between the humeral head and the acromial process. The patient was recommended for an orthopedic consult which was completed on 01/05/12. The consult indicated that the rotator cuff tear was irreparable and the patient was not recommended for surgical intervention. The patient was recommended for physical therapy, use of anti-inflammatories, injections, and rest. The patient was also recommended to stay away from any manual labor. Orthopedic follow-up on 04/16/12 stated that the patient has had some mild improvement in pain with physical therapy but continued to report weakness and limited range of motion in the left shoulder. Medications included Hydrocodone for pain control. Physical examination revealed muscular wasting in the supraspinatus and infraspinatus muscle bodies of the left shoulder. There was tenderness to palpation over the anterior and posterior subacromial space. Range of motion was significantly restricted on abduction and forward elevation; however, it is unclear if this was an active or passive finding. Radiographs showed osteoarthritic changes of the left shoulder. A designated doctor evaluation completed on 07/03/12 recommended further consideration for surgical repair of the rotator cuff. Orthopedic follow-up on 08/22/12 indicated that the patient was note interested in surgical repair of the left rotator cuff. Follow-up on 09/05/12 stated that the patient had persistent loss of range of motion in the left shoulder. Physical examination revealed stiffness in the left shoulder with 105 degrees of elevation. There was limited rotation in the left shoulder. The patient was recommended for the use of a DynaSplint for the left shoulder. Radiographs performed on 09/06/12 showed continuing mild superior subluxation of the humeral head in relationship to the subacromial space.

The request for manipulation under anesthesia of the left shoulder was denied by utilization review on 11/26/12 as there was no documentation regarding physical therapy or other conservative measures such as activity modifications and injections. There was also no updated physical examination or MRI studies.

The request was again denied by utilization review on 12/27/12 as there was no updated physical therapy documentation or an updated physical examination.

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

The patient has had ongoing complaints of left shoulder pain with loss of range of motion. From the initial MRI study, this is definitely due to a very large and chronic rotator cuff tear involving both the supraspinatus and infraspinatus tendons. Exam findings have been very consistent with a large rotator cuff tear and there is no clear updated evidence regarding a frozen shoulder condition that would reasonably benefit from a manipulation under anesthesia procedure. The clinical documentation provided for review does not contain an updated physical examination showing significant loss of range of motion both passively and actively that would support the use of manipulation under anesthesia procedure. There is also no clinical documentation regarding any recent conservative treatment, such as physical therapy use of a dynasplint or injections that have been recommended by several physicians. As the clinical documentation provided for review does not meet guideline recommendations regarding manipulation under anesthesia, the surgical request is still not supported. It is the opinion of the reviewer that the request is not medically necessary.

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**

Official Disability Guidelines, Online Version, 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. (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 anesthsia 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.