



3250 W. Pleasant Run, Suite 125 Lancaster, TX 75146-1069
Ph 972-825-7231 Fax 972-274-9022

Notice of Independent Review Decision

DATE OF REVIEW: 1/15/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of Recon right shoulder arthroscopy poss subacromial decompression poss distal clavical resection poss open RCR poss open lysis of adhesions MUA and poss RC repair 23420 23130 23120 23429 29826 29823 27300.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of Recon right shoulder arthroscopy poss subacromial decompression poss distal clavical resection poss open RCR poss open lysis of adhesions MUA and poss RC repair 23420 23130 23120 23429 29826 29823 27300.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

Texas Department of Insurance & Corvel

These records consist of the following (duplicate records are only listed from one source):

Records reviewed from Texas Department of Insurance

Texas Department of Insurance

Intake paperwork

Records reviewed from Corvel

Corvel

Denials- 11/7/12, 12/7/12

M.D.

Rationale for Preauthorization- 11/6/12, 12/7/12

Diagnostic Imaging

MRI of the right shoulder- 10/18/12

Orthopaedics

Office Notes- 10/24/12, 10/15/12, 9/12/12, 8/3/12, 7/2/12, 4/3/12

Imaging

CT C Spine w/ Contrast- 7/24/12

Myelogram C Spine- 7/24/12

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Attending Physician records were reviewed. The claimant was noted to have an unknown shoulder mechanism of injury. The claimant did have a prior history of having undergone an Open Reduction with Internal Fixation of the humerus on 11/13/11 with a scar noted at the affected shoulder. The claimant had complaints of persistent pain and motion loss despite medications and Physical Therapy. Exam findings included shoulder muscle atrophy. There was finger swelling and shiny skin, along with considerations of complex regional pain syndrome and stellate ganglion block considerations. Passive flexion was to 90 degrees. An MRI dated 10/18/12 revealed post-op. changes with complex fracture and relative flattening of humeral head. AC arthropathy was noted. Overall the study was noted to be "limited" as per the radiologist. A 7/21/12 dated cervical CT-myelogram revealed degenerative changes, disc protrusion and a prior fusion. Denial letters revealed the lack of specific records of therapy and injection treatments, along with a lack of night pain, weak abduction and/or a painful arc of impingement/motion. Reference to a lack of prior PT compliance and the lack of electrical studies was also noted.

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

Recommend denial of requested services. The claimant has multiple co-morbid issues that render the prognosis for the requested procedure to be worse than guarded. These include the possible complex regional pain syndrome stigmata of pain in the affected extremity, with swelling and shiny skin. In addition, there is the lack of full differentiation of radiculopathy as

evidenced by the atrophic shoulder and cervical spondylitic changes on the imaging studies. Electrical studies are not provided and therefore contribution of the condition from a radiculopathy standpoint cannot be fully ascertained at present. In addition, evidence of a full (with compliance issues noted) record of a trial and failure of specific therapy and medications have not been submitted. A painful motion arc has also not been documented. Guideline criteria for impingement, cuff tear and/or indication for the requested procedures has not been fully documented or met, at this time.

Reference: ODG Indications for Surgery

-- Acromioplasty:

Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.)

- 1. Conservative Care:** Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS
- 2. Subjective Clinical Findings:** Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS
- 3. Objective Clinical Findings:** Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS
- 4. Imaging Clinical Findings:** Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement. ([Washington, 2002](#))

ODG Indications for Surgery -- Rotator cuff repair:

Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out:

- 1. Subjective Clinical Findings:** Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS
- 2. Objective Clinical Findings:** Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS
- 3. Imaging Clinical Findings:** Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.)

- 1. Conservative Care:** Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS
- 2. Subjective Clinical Findings:** Pain with active arc motion 90 to 130 degrees. AND Pain at night (Tenderness over the greater tuberosity is common in acute cases.) PLUS
- 3. Objective Clinical Findings:** Weak or absent abduction; may also demonstrate atrophy.

AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS
4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff. ([Washington, 2002](#))

ODG Indications for Manipulation under Anesthesia:

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.

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
- 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)