



**MEDICAL EVALUATORS
OF TEXAS** ASO, L.L.C.

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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 4, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder manipulation under anesthesia

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

This case was reviewed by a physician who holds a board certification in orthopedic surgery and is currently licensed and practicing in the State of Texas.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a female who injured her left shoulder. She hit her left shoulder on a bar and felt immediate pain in her left shoulder. She was seen and had x-rays of the left shoulder dated 01/11/2013 showed no evidence for fractures or dislocations, osteomyelitis or erosive changes of the left shoulder. She was diagnosed with posttraumatic shoulder pain, posttraumatic frozen shoulder, as well as AC joint arthropathy. She was then treated with physical therapy which helped improve her motion but the further physical therapy was denied. She also tried home exercises that did not help. On 12/16/2013, she followed up for follow up of her left shoulder. On physical exam of her extremities, her bilateral lower extremity and right upper extremity range of motion was nonpainful. Her left shoulder range of motion was painful and limited with only 100 passive/active ROM in abduction. There had been minimal improvements over serial clinic visits despite aggressive conservative measures. She had very limited internal and external rotation as



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well secondary to pain. recommended left shoulder under anesthesia due to her persistent left shoulder pain and stiffness resulting in adhesive capsulitis and not responding to aggressive physical therapy and rehab exercises.

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

This is a refractory case of adhesive shoulder capsulitis per submitted documents. She has undergone numerous conservative treatments including medications, voltaren gel, formal physical therapy, and dynasplinting. Her ROM remains significantly limited only to 100 passive/active at last clinic visit. The ODG clearly supports this treatment modality as an option in refractory cases of adhesive capsulitis. The treating surgeon has clearly exhausted conservative modalities and the patient has failed to improve. I think that MUA is warranted and supported per ODG guidelines and clinical studies cited below.

ODG – Chapter – Shoulder (Acute and Chronic) 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



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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) In this study, six months after MUA, endurance time and net impulse remained impaired for the involved shoulder. (Sokk, 2013) According to an Indian study, the efficacy of MUA, injection, and PT are comparable for adhesive capsulitis. (Ghosh, 2012) It is currently unclear as to whether there is a difference in the clinical effectiveness of an arthroscopic capsular release compared to MUA in patients with recalcitrant idiopathic adhesive capsulitis. The quality of evidence available is low and the data available demonstrate little benefit. A high quality study is required to definitively evaluate the relative benefits of these procedures. (Grant, 2013) See also Surgery for adhesive capsulitis. In other chapters, see the Low Back Chapter, where MUA is not recommended in the absence of vertebral fracture or dislocation; and the Knee Chapter, where MUA is recommended as an option for treatment of arthrofibrosis and/or after total knee arthroplasty, only after a trial (six weeks or more) of conservative treatment, and a single treatment session would then be recommended, not serial treatment sessions.

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



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- 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)