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An Independent Review Organization

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Notice of Independent Review Decision

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Manipulation under anesthesia of the left shoulder, injection of the left shoulder following manipulation

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)

Patient Clinical History (Summary)

Patient is a female. On 09/24/14, an MRI of the left shoulder revealed supraspinatus tendinopathy without structural significant rotator cuff tear. On 10/07/14, the patient was seen for initial orthopedic consultation. She reported an on the job injury to the left shoulder, left forearm and left side of her neck. She stated she was lifting a heavy box and pulled it forward and began having pain to the shoulder with weakness in her shoulder. She reported no improvement with conservative care including analgesic, anti-inflammatories, muscle relaxants and physical therapy. On exam, there was tenderness over the left shoulder and over the medial epicondyle of the left elbow. She had a positive impingement test and a negative drop arm test. She had a negative Spurling compression test. On 10/28/14, the patient returned to clinic, and Corticosteroid injection was given to her left shoulder and left AC joint. She had decreased range of motion in the left shoulder secondary to pain. On 11/04/14, the patient returned to clinic and noted slight improvement with the steroid injection to the left shoulder. On 11/11/14, the patient was seen in clinic. On exam she had tenderness over the left shoulder, and a positive impingement test. She had negative tests for a SLAP tear. Surgery was recommended. On 03/03/15, the patient returned to clinic. It was noted surgery had been recommended previously but there was a dispute with Workers' Compensation. On 05/19/14, the patient was seen in clinic. She was status post arthroscopy of the left shoulder on 03/16/15, and there were no sensory or motor deficits. She reported increased range of motion and increased strength and decreased pain. Continuation of physical therapy was recommended. On 06/16/15, the patient returned to clinic. She reported decreased active and passive range of motion of the shoulder and only noted slight improvement with physical therapy. On exam, it was noted she had decreased active and passive range of motion of the left shoulder. She had a negative impingement test. Manipulation under anesthesia of the left shoulder with an injection was recommended.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 06/22/15, a peer review considered the request for manipulation under anesthesia of the left shoulder as well as an injection of the left shoulder following manipulation. It was noted that there were no numerical values to be able to determine the extent of the deficits to the left shoulder and it was difficult to track progress with postoperative therapy without documentation of specific numerical values for motion. There was no plan for arthroscopic release which would lead to an increased risk for stiffness and need for another revision surgery and therefore the request for manipulation was non-certified. Post-

manipulation under anesthesia injection was also not indicated as being medically necessary. A letter was submitted on 06/23/15, notifying the patient the request was non-certified. On 06/30/15, a reconsideration peer review considered the same request, and again utilized Official Disability Guidelines. It was noted that the values of range of motion were not noted on exam provided for review and there was no documentation of an injection having been tried after surgery date of 03/16/15 and therefore the request for manipulation was not necessary. The request for the injection of the left shoulder following manipulation therefore was not considered medically necessary.

For this review, the Official Disability Guidelines Shoulder Chapter will also be utilized as in the previous 2 determinations. It is noted that manipulation under anesthesia may be an option in adhesive capsulitis, in cases that are refractory to conservative care lasting at least 3-6 months where range of motion remains significantly restricted with abduction of less than 90 degrees. The records provided for this review include the last clinical note dated 06/16/15, in which the physical examination showed decreased active and passive range of motion of the left shoulder. Numerical values for range of motion in abduction, forward flexion, and internal and external rotation were not stated. Therefore, the requested manipulation under anesthesia at the left shoulder would not be supported due to documentation of specific range of motion deficits. Additionally, there is also a lack of significant documentation regarding conservative care in the form of physical therapy following the 03/16/15 surgical intervention. Therefore, there is a lack of documentation of 3-6 months of physical therapy as recommended by guidelines and the request would not be supported due to the lack of documentation of conservative measures. A steroid injection may be given for a diagnosis of adhesive capsulitis, when pain is not controlled adequately by recommended conservative treatments such as physical therapy and exercise. With the lack of objective evidence indicating the amount of physical therapy given, and with the manipulation under anesthesia not being considered reasonable, there would be no need for an injection at the left shoulder following manipulation. Therefore, it is the opinion of this reviewer that the request for a manipulation under anesthesia of the left shoulder, injection of the left shoulder following manipulation is not medically necessary and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPH-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)