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Notice of Independent Review Decision

**Date notice sent to all parties: 12/17/14**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Left shoulder manipulation under anesthesia (MUA)

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

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)

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

Left shoulder MUA - Upheld

The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

**PATIENT CLINICAL HISTORY [SUMMARY]:**

A left shoulder MRI dated 10/05/12 revealed advanced degenerative arthropathy of the AC joint with reactive bone marrow edema in the distal clavicle and

acromion. There was tendinopathy of the superior tendon components of the rotator cuff with no evidence of rotator cuff tear. examined the patient on 01/23/14. He was lifting an object on xx/xx/xx from a surface of about three to five feet off the ground. He was bent over at the waist when the injury occurred. He had pain in the left shoulder, lumbar spine, bilateral neck, the right shoulder, and the bilateral mid back. His carriage and gait displayed noticeable difficulty and he had an antalgic position of the low back on the right. Toe and heel walking were normal and supraspinatus testing and Lasegue's were positive in the left shoulder. He had severe cervical, thoracic, and lumbar region tenderness. Left shoulder flexion was 90 degrees, extension was 30 degrees, abduction was 85 degrees, and adduction was 20 degrees all with muscle spasm. Lumbar flexion was 90 degrees, extension was 30 degrees, and bilateral rotation was 15 degrees. The diagnoses were shoulder impingement, lumbar radiculitis, lumbar IVD disorder without myelopathy, cervical radiculitis, cervical IVD disorder without myelopathy, and thoracic sprain/strain. He was felt to be unable to return to work through 02/17/14. Ten visits of therapy over eight weeks was recommended to include kinetic exercises, manual therapy, therapeutic exercises, as well as home exercises for the left shoulder. noted it was his medical opinion that if there were any preexisting conditions, they were aggravated by the xx/xx/xx on the job injury. The patient attended therapy with on 02/13/14, 03/10/14, and 03/21/14. He complained of severe lumbar and cervical pain in these notes, but only received treatment for the left shoulder to include kinetic exercises, manual therapy, and therapeutic exercises. performed left shoulder diagnostic arthroscopy with subacromial decompression, acromioplasty, debridement of the labral tear, removal of adhesions, open rotator cuff tear, and microtenotomy of the rotator cuff on 04/29/14. The postoperative diagnoses were impingement syndrome, labral tear, adhesions, and complete rotator cuff tear. On 05/02/14, a pneumatic intermittent compression device was requested. reevaluated the patient on 05/13/14. He had a slight tingling sensation and felt a little burning in the left shoulder. His range of motion was reduced in the left shoulder and there was no erythema, purulence, or signs of infection. His sutures and staples were removed. He was advised to attend therapy three times a week for four to six weeks. His medications were continued as needed. On 05/22/14, requested 40 visits of therapy over 16 weeks. The patient attended therapy on 06/20/14, 06/23/14, 06/25/14, 06/27/14, 06/30/14, 07/03/14, 07/11/14, 07/15/14, 07/23/14, 07/24/14, and 07/31/14. The treatment he received was unchanged. On 07/24/14, he was 2% improved. reexamined the patient on 06/26/14. He had completed five sessions of therapy at that time and noted it was due to a denial by the carrier. He had pain rated at 6/10 and a lack of strength and motion in the left shoulder. It was noted he had a prior laminectomy at L4-S1 in 1989. He was 73 inches tall and weighed 200 pounds. Active forward elevation was significantly less than active, which was less than 90 degrees. Strength was 3/5 in all rotator cuff groups tested. He had tenderness of the proximal humerus, bicipital groove, and subacromial space. The assessments were rotator cuff syndrome NOS and sprain of shoulder NOS. advised the patient to continue in therapy. wrote a certificate of medical necessity on 06/26/14 for a TENS unit with supplies and conductive garment. reevaluated the patient on 07/31/14. He continued with left

shoulder, lumbar, cervical, right shoulder, and bilateral mid back pain. He had hypoesthesias of the C6 on the left and C7 and T1 on the right and there was hyperesthesias at L5 and S1 on the right. Supraspinatus testing was positive on the right. Left shoulder flexion was 110 degrees, extension was 55 degrees, abduction was 100 degrees, and adduction was 35 degrees. He had completed 18/40 postoperative visits and had demonstrated improvements in strength and range of motion. requested the additional 22 sessions at that time, as he was not currently stationary. The treatment to be provided would be unchanged. The patient continued in therapy on 08/05/14, 08/08/14, 08/15/14, 08/18/14, 08/21/14, 08/22/14, 08/25/14, 08/27/14, 08/29/14, 09/03/14, and 09/04/14. The treatment provided was unchanged. On 08/15/14, he had no notable progress. On 08/27/14, it was noted he had no substantial improvement. He continued with limitations of movement and pain in the left shoulder that was unchanged from the last visit. He continued with radiating lumbar pain and muscle spasms and cervical muscle spasms and pain in the bilateral neck that radiated to both arms. There did not appear to be a shoulder examination. followed-up with the patient on 09/25/14. He had completed 20 sessions of therapy and still had problems raising his arm after an eight week delay of postoperative therapy. Active forward flexion was 110 degrees and was noted to be significantly less than passive motion. Abduction was 95 degrees and strength testing was 3/5. He remained tender over the proximal humerus and bicipital groove. Impingement sign was positive, as was Hawkin's sign. He had tenderness of the subacromial space and AC joint. The assessments were unchanged. felt the patient had a mechanical block and acquired a frozen shoulder. He felt the patient would require MUA followed by therapy for maximizing joint motion and overall strength. It was also felt he would require a CPM chair unit. It was noted he was scheduled for an RME on 10/17/14. On 10/14/14 an orthopedic surgeon provided an adverse determination for the requested left shoulder MUA. provided a reconsideration request on 11/04/14 for the left shoulder MUA. On 11/19/14 an orthopedic surgeon, provided another adverse determination for the requested left shoulder MUA.

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

The patient is a male who reported injuring his left shoulder in a lifting accident on xx/xx/xx. There is minimal medical documentation between the work related injury and 01/23/14. A left shoulder MRI scan performed on 10/05/12 documented no rotator cuff tear, but advanced left acromioclavicular joint arthrosis with tendinopathy. The first medical is dated 01/23/14. The patient then underwent a surgical procedure on 04/24/14 to include left shoulder arthroscopy with subacromial decompression, debridement of labral tear, open rotator cuff repair, and microtenotomy of the rotator cuff for unclear reasons, since the MRI scan did not document any evidence of complete rotator cuff tear.

The patient has subsequently completed chiropractic directed physical therapy without any objective evidence of improvement. documented on 09/25/14 active

flexion to 110 degrees with active abduction of 95 degrees. He, at that point, recommended MUA and continuous passive motion. The MUA was denied on initial review on 10/14/14 by orthopedic surgeon. His denial was upheld on reconsideration/appeal. Both reviewers attempted peer-to-peer and spoke was unable to provide any additional supportive information. Both reviewers noted that the requested procedure did not meet the criteria of the ODG.

MUA, according to the ODG, is under study as an option in adhesive capsulitis. In cases that are refractory to conservative therapy lasting at least three to six months, where range of motion remains significantly restricted (abduction less than 90°), MUA may be considered. There is some support for MUA based on consistent positive results from multiple studies, although these studies are not high quality (Colorado 1998, Kivimaki 2001, Hamdan 2003). 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 motion and to improve early function in this often protracted and frustrating condition (Andersen 1998, Dodenhoff 2000, Cohen 2000, Othman 2002, Castellarin 2004). Even though MUA is effective in terms of joint mobilization, the method can cause iatrogenic intrarticular damage (Loew 2005). When performed by chiropractors, MUA 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 MUA is a very simple and non-invasive 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 intrarticular local anesthesia shorten the course of frozen shoulder, although it is apparently a self-limiting disease (Kahn 2009). In this study, MUA combined with arthroscopy was effective for 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 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 (Vastamaki 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. Generalized ability is somewhat unclear because of limited information about previous interventions that participants had received and stage of frozen shoulder (Maud 2012). The fastest improvement occurs following the

first month after MUA, but six 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 physical therapy, 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 demonstrates little benefit. A high quality study is required to definitively evaluate the relevant benefits of these procedures (Grant 2013).

The requested left shoulder MUA does not meet the criteria of the evidence based ODG, as outlined above, in particular the range of motion deficit that is required. In addition, he has had extensive physical therapy without any evidence of clinical improvement. Both the evidence based ODG and Medical Disability Advisor (MDA) recommend addressing of non-physical factors (psychosocial, work place, socioeconomic) in cases of delayed recovery or return to work. Non-physical factors can be a significant impediment to functional restoration. Therefore, the requested left shoulder MUA is not appropriate nor in accordance with the recommendations of the ODG and the previous adverse determinations should be upheld at this time.

**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)