



**MEDICAL EVALUATORS
OF T E X A S ASO, LLC.**

2211 West 34th St. • Houston, TX 77018
800-845-8982 FAX: 713-583-5943

Notice of Independent Review Decision

DATE OF REVIEW: October 02, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Evaluation under anesthesia, open manipulation, with lysis of adhesions, decompression, AC resection and biceps tenodesis; CPT: 29825, 29824, 29823, 23430

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)

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This claimant sustained an injury to his right shoulder on xx/xx/xx as he was opening heavy doors and he felt a pop in his right shoulder. The claimant was diagnosed with right impingement syndrome, right AC joint osteoarthritis, right adhesive capsulitis, right rotator cuff tear (degenerative/partial thickness), and right bicipital tenosynovitis. The claimant's past medical treatment includes medications, physical therapy, and 2 injections. Temporary relief was noted after second injection. The medication list includes ibuprofen, naproxen, tramadol and Tylenol/Codeine.

An MRI of the right shoulder dated 06/08/2015 revealed osteoarthritic changes of the glenohumeral joint, rotator cuff tendinosis and biceps tenosynovitis. There were also changes suggestive of adhesive capsulitis.

A progress note dated 08/20/2015 indicates the claimant complained of decreased right shoulder motion, giving away, crepitus, catching and weakness in the right shoulder. The physical examination of the right shoulder revealed diffuse tenderness at the AC joint and over the biceps tendon, marked limitation of motion, diffuse weakness, strength limited secondary to pain, no joint instability on provocative testing, positive AC joint compression test, positive cross chest abduction test and positive impingement test. The claimant was



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recommended right shoulder arthroscopic lyses of adhesions with a decompression of the subacromial space and AC interval and all other indicated procedures since the claimant's symptoms failed to resolve since the injury after physical therapy, injections, time, medications, and modification of activities. The claimant has not had prior surgery for this injury. The claimant as a past medical history significant for rotator cuff repair in 2002.

A denial letter of unknown date denied the requested services of evaluation under anesthesia, open manipulation, with lysis of adhesions, decompression, AC resection and biceps tenodesis because the ODG does not recommend surgery for adhesive capsulitis as this condition is considered to be self-limiting and generally results with long-term conservative treatment. The stated date of injury for the employee was only xxxxxx and it is unclear how much physical therapy or other treatment has been rendered. Additionally, a mobilization under anesthesia is also not recommended except for cases that persist despite conservative treatment for at least 3 to 6 months and there should be physical examination findings of less than 90°. The physical examination on 08/20/2015 does indicate decreased right shoulder range of motion. However, this is not objectified. Considering the stated date of injury, physical examination findings and guideline recommendations, this request for a right shoulder manipulation under anesthesia, lysis of adhesions, decompression, AC resection and biceps tenodesis is not medically necessary.

A denial letter of unknown date denied the requested services of evaluation under anesthesia, open manipulation, with lysis of adhesions, decompression, AC resection and biceps tenodesis because there are marginal degenerative changes identified on MRI and that the current physical examination does not establish a severe limitation to range of motion, to consist of a diagnosis of adhesive capsulitis. There is no clear clinical indication to support this surgical intervention.

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

According to the ODG, manipulation under anesthesia may be considered for adhesive capsulitis in cases when range-of-motion remains significantly restricted (abduction less than 90°). The records available for review documents that the claimant has decreased range of motion of the right shoulder, but there is no documentation of objective range of motion values indicating significantly restricted abduction of less than 90°. The available records indicate that the diagnosis of adhesive capsulitis is not supported by the objective findings. The right shoulder MRI dated 06/08/2015 shows degenerative changes and there is no indication to support that requested surgical procedure is related to the injury sustained on. Additionally, the ODG criteria for biceps tenodesis is type IV lesions such as more than 50% of the tendon involvement, vertical or bucket-handle tear of the superior labrum, extending into biceps or intrasubstance tear as well as patients undergoing concomitant rotator cuff repair. The right shoulder MRI dated 06/08/2015 shows fraying of the bicipital labral complex but no evidence of tear. The records do not indicate that this



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claimant has met the ODG criteria and therefore, the requested surgical procedure is not medically necessary and appropriate.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Shoulder (Acute & Chronic) - (updated 09/08/15) – Online Version 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 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



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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) According to a systematic review of frozen shoulder treatments, outcomes with MUA are equivocal when compared to other treatment approaches. (Uppal, 2015) This study concluded that the best time for MUA, if non-operative treatment has failed to alleviate pain or limitation of shoulder motion is too cumbersome, might be between 6 and 9 months from the onset of the symptoms. (Vastamäki, 2015) 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.

Criteria for Surgery for Biceps tenodesis:

- After 3 months of conservative treatment (NSAIDs, PT)
- Type II lesions (fraying and some detachment)
- Type IV lesions (more than 50% of the tendon is involved, vertical tear, bucket-handle tear of the superior labrum, which extends into biceps, intrasubstance tear)
- Generally, type I and type III lesions do not need any treatment or are debrided
- Also patients undergoing concomitant rotator cuff repair
- History and physical examinations and imaging indicate pathology
- Definitive diagnosis of SLAP lesions is diagnostic arthroscopy
- Age (otherwise consider SLAP repair).

ODG Indications for Surgeryä -- 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



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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 MRI, ultrasound, or arthrogram shows positive evidence of impingement.

ODG Indications for Surgeryä -- Partial claviclectomy:

Criteria for partial claviclectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint:

1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS
2. Subjective Clinical Findings: Pain at AC joint; aggravation of pain with shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS
3. Objective Clinical Findings: Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS
4. Imaging Clinical Findings: Conventional films show either: Post-traumatic changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation.