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Notice of Independent Review Decision

August 10, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Manipulation under Anesthesia RT Shoulder

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

The Reviewer is a board Certified Orthopaedic Surgeon with over 13 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

(Agree)

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained a work related injury to his right upper extremity on xx/xx/xx. dropped 100lb object on the claimant causing his right elbow and shoulder injury. Claimant underwent right elbow and shoulder surgeries, treatment with NSAID's, activity modifications and therapy.

xxxx: Office visit. **Right Elbow:** Tenderness at the medial epicondyle. Medial aspect elbow scare tenderness, ROM: Right/Left: 130/140. Extension 0/0. Supination 70/80. Pronation 70/80/ +2 radial pulse. Right wrist/hand: Normal allen test of the hand. +2 radial and ulnar pulses. Brisk cap refill all digits. Motion: Diminished sensation in ulnar nerve distribution. Tinel at cubital tunnel. Wrist ROM: R/L: Volar flexion -70/80. Dorsal flexion -60/70/ Ulnar deviation-20/30. Radial deviation -15/15. **Right elbow x-rays 3 views xxxx:** Impression: No fracture/dislocation DJD. Right elbow protector elastic orthosis is applied and adjusted.

xxxx: MRI of Right elbow. **Impression:** 1. Geode formation of the radiocapitellar joint suggesting osteoarthritis change.

xxx: Office visit. Claimant was seen status post right elbow medial epicondyle surgical partial excision/debridement on xxxx. Pain is well controlled.

xxxx: Office visit. Claimant was seen for post right elbow medial epicondyle surgical partial excision/debridement

done on xxxx. **Assessment:** Increased symptoms. Will inject steroids.

xxx: Office visit. Claimant was seen status post right elbow medial epicondyle surgical partial excision/debridement. Reported less right elbow pain after the steroid injection. Still C/O right elbow stiffness/weakness.

xxxx: Office visit. Claimant reported increased sharp pain and is requesting steroid injections. **Plan:** Right elbow epicondylitis- increased symptoms. Will inject steroids.

xxx: Office visit. Claimant was seen for follow up. **Medications:** Ultram 50mg, Ibuprofen, Cymbalta. Recent right shoulder CT- No significant findings. Right elbow CT- inconclusive, MRI is recommended by radiologist.

xxxx: CT Upper extremity w/o contrast. **Impression: 1.** Ulnar nerve enlargement with surrounding standing. Findings suggest recent operative intervention, suspect ulnar nerve release. These findings could potentially be further evaluated in greater anatomic detail with elbow MRI. **2.** No evidence of abnormal postoperative fluid collection or impinging lesion.

xxxx: MRI of the right elbow. **1.** Findings consistent with surgical treatment of lateral epicondylitis with expected postoperative appearance. **2.** Evidence of previous anterior subcutaneous ulnar nerve transposition with new muscle edema in the adjacent proximal flexor musculature that is nonspecific but could be seen with muscle strain, myositis or conceivably neurogenic change but without associated muscular atrophy.

xxxx: Office visit. **HPI:** Claimant underwent right elbow and shoulder surgeries, treatment with NSAID's, activity modification and therapy. Claimant present-still C/O right elbow, and recently increased shoulder pain/stiffness. The pain scale at rest is 5-6/10. More pain with right upper extremity use for activities of daily living. **Right Shoulder:** Tenderness at lateral and anterior aspect of the shoulder joint. Forward elevation R-110, L-180, Abduction: R-110, L160. ER: R50, L-80. IR: R-S1 level, L-L4 level. + impingement sign. **Right Elbow:** Some medial aspect swelling. Tenderness at the lateral epicondyle. Tenderness at the medial epicondyle. Medial aspect elbow scare tenderness. **ROM:** Right/left: Flexion 130/140. Extension 0/0. Supination 70/80. Pronation 70/80. **Right elbow x-rays:** 3 views (xxxx), no fracture/dislocation/DJD. **Right shoulder MRI (xxxxx)** ,Flexor Myositis without muscle atrophy.

xxxx: UR. Rationale for denial: Patient is a male with a date of injury on xx/xx/xx. No functional limitations have been given. He has previously had a subacromial decompression in xxxx. He has had an ACDF to his cervical spine with a pseudarthrosis, and multiple elbow operations for epicondylitis. No descriptions of conservative treatment are given. The indications are not met, the treatment is not medically necessary.

xxxx: UR. Rationale for denial: xx is a xx-year-old. Mechanism of injury: 100lb object was dropped onto the Rt shoulder. No documentation of failure of PT, HEP, CSL per ODG guidelines. It is not medically necessary to proceed with the requested procedure.

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

The patient does not require a right shoulder manipulation under anesthesia.

The Official Disability Guidelines (ODG) supports shoulder manipulation in patients with adhesive capsulitis who have significantly restricted shoulder motion (abduction less than 90 degrees), following 3-6 months of conservative treatment.

A subacromial decompression was performed on this patient's right shoulder in xxxx. In xxxx, the patient is noted to have right shoulder motion consisting of 110 degrees of abduction, 110 degrees of forward elevation, 50

degrees of external rotation, and internal rotation to S1. It is unclear whether the recorded shoulder motion is active or passive. Limited active motion with full passive motion may reflect rotator cuff pathology, associated with a positive impingement sign, not adhesive capsulitis.

The patient does not meet the ODG criteria of significantly restricted shoulder motion, consisting of abduction less than 90 degrees. There is no documentation of conservative treatment with physical therapy, dynamic splinting, or cortisone injections to improve shoulder motion. In addition, the medical record does not indicate the functional impairment that the patient currently has as a result of his shoulder motion.

The request for shoulder manipulation is denied.

ODG Guidelines:

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](#)) 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.

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)