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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Shoulder Arthroscopy W/Manipulation, 23700, 29805

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:

Overturned (Disagree)

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 an injury on XX/XX/XXXX while pulling a dolly that had a heavy weight on it. The claimant was diagnosed with right shoulder post-operative adhesive capsulitis.

12/09/2014: X-ray of right shoulder, two views. **Impression:** Mild degenerative change at the AC joint.

12/09/2014: Office visit. **HPI:** Claimant reported he was seen by his primary care physician and given a steroid injection in the hopes that this would help. He was sent to PT as well, but his symptoms continued. He notices discomfort with simple ROM and has more difficult tasks as far as raising his arm. Denies numbness and tingling distally. He is currently working, on light duty and continues to do PT three times a week. **Medications:** Metformin, Benicar. **PE:** No abnormal swelling or deformity in the right upper extremity. Patient is very limited in ROM with abduction as well as with straight arm raises which creates discomfort and pain through the top as well as the anterior and posterior areas of the shoulder. He has weakness with drop arm testing as well as resistance to straight arm raises. He has good ROM at the elbow. Impingement sign is positive Empty can test positive. **X-ray:** Shows the patient to have some arthritic changes throughout the AC joint, but no fracture or loose body is identified. **Plan:** Continue PT. Recommended steroid injection.

01/13/2015: Office visit. **PE:** Patient has pain with flexion and abduction. He has tenderness to palpation over the AC joint. He has tenderness to palpation over the humeral head. Findings remain consistent with bursitis and impingement syndrome and even a rotator cuff injury. **Plan:** patient failed conservative treatment, recommended a right shoulder scope and MRI.

01/30/2015: MRI of extremity upper joint W/O Contrast. **Impression:** 1. Extensive slap tear. 2. High-grade partial thickness tear of the infra spinatus. 3. AC joint arthropathy.

02/10/2015: Office visit. Claimant reported he gets about 90 degrees with side raises and then has pain and discomfort. He stated that his injection shot he received back in December did help some but his symptoms never completely resolved. He continues to work but has pain and discomfort. **Plan:** Recommends arthroscopy of the right shoulder.

05/18/2015: Operative report. Right shoulder Post Op: 1. Partial articular-sided rotator cuff tear. 2. Slap tear. 3. Impingement syndrome and acromioclavicular arthropathy.

06/01/2015: Office visit. Follow up of arthroscopy of the right shoulder with biceps tendosis. Claimant reported stiff in the right shoulder. He is doing PT. Claimant reported no significant complaints.

07/14/2015: Office visit. Claimant reported he continues to have pain and discomfort in the right shoulder. Workers' Comp has discontinued PT sessions. He reported he has pain in the scapula and limited ROM secondary to pain. Denies any numbness, tingling, or any other abnormalities in the right upper extremity. **PE:** Claimant does have limited ROM with abduction and straight arm flexion secondary to the pain that he expresses. He has pain with palpation over the anterior and posterior muscles. **Plan:** Claimant received steroid injection into the right should. Recommended PT.

08/10/2015: Office visit. Claimant reported to struggling with his right shoulder. Complains of stiffness and pain. He missed a significant portion of PT. PT was cancelled by WC. Claimant reported he missed one month of PT, but did restart but continues to struggle with ROM upon resuming PT. He reported pain in the shoulder that will radiate into the upper arm and into the neck. **Medication:** Metformin and Benicar. **PE:** Active forward flex to 30 degrees and passive forward flexion only to 35 degrees. He can internally rotate only to the iliac crest. He has normal sensation throughout the right upper extremity and a palpable radial pulse. Attempts at any manipulation testing of the should is not possible due to significant guarding. **Plan:** Claimant is post 3 months out from his arthroscopy of the right shoulder but has developed significant stiffness. His passive ROM is no better than his active ROM. His exam is very consistent with adhesive capsulitis. He has failed PT and injections. I would recommend manipulation under anesthesia of the right shoulder along with a diagnostic arthroscopy with possible glen humeral joint debridement of the capsulitis.

08/14/2015: UR. Rationale for denial: The patient is a male who sustained an injury on xx/xx/xxxx while pulling a dolly. The patient was diagnoses with right shoulder post-operative capsulitis. His exam is very consistent with adhesive capsulitis. He has failed PT and injections. However, the CPT code 29805 is for a diagnostic arthroscopy and is only recommended if imaging inconclusive. No imaging post-surgery was submitted. The case cannot be partially certified without peer to peer discussion and agreement as such must be denied in its' entirety. Given the above, the request for an Arthroscopy with Manipulation, right shoulder 23700, 29805 is non certified.

08/21/2015: UR. Rationale for denial: The claimant is a male who sustained an injury on xx/xx/xxxx while pulling a dolly. The patient is diagnosed with right shoulder post-operative adhesive capsulitis. An updated medical report addressing the issues of the previous determination was not submitted for review. Given that this patient has symptoms and exam findings consistent with post-operative adhesive capsulitis, and there is persistence of symptoms despite conservative care with PT, medications, and injection, the requested manipulation under anesthesia of the right shoulder is considered. As for the request to CPT code 29805 which refers to diagnostic arthroscopy, ODG states that diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. However, an updated anesthesia is reasonable. However, as the request for CPT code 29805 was not supported, the request in its entirety is not supported. , the medical assistant with advised the patient has had adhesive capsulitis for over 6 months and has failed PT. also informed me that she would fax the MRI for review. While, the MUA would be supported, a mutual agreement for treatment modification could not be made as the requesting physician was not available. Therefore, in agreement with the previous determinations, the medical necessity of the request has not been

established.

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

The requested shoulder arthroscopy and manipulation under anesthesia (MUA) are medically necessary for this patient.

The patient is currently dealing with a stiff shoulder following an arthroscopic procedure. His examination is consistent with adhesive capsulitis.

The Official Disability Guidelines (ODG) supports manipulation under anesthesia (MUA) in cases of adhesive capsulitis (abduction less than 90 degrees) that have failed 3-6 months of conservative treatment. The patient meets criteria for a MUA.

Arthroscopy of the shoulder is typically performed in conjunction with MUA. Frequently there are adhesions within the shoulder joint and subacromial space that limit shoulder motion, especially following a previous surgical procedure. These adhesions cannot be identified on a MRI. The purpose of the arthroscopy is to identify these adhesions and release them. The arthroscopic procedure allows for additional shoulder motion that would not ordinarily be achieved with MUA alone.

Therefore, the requested procedure is approved.

ODG Guidelines:

Recommended as indicated below. **Criteria** for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear. ([Washington, 2002](#)) ([de Jager, 2004](#)) ([Kaplan, 2004](#))

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)