C-IRO Inc.

An Independent Review Organization
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08/21/18

Description of the service or services in dispute:
Right shoulder manipulation under anesthesia.
23700 - Manipulation Procedures on the Shoulder

Description of the qualifications for each physician or other health care provider who reviewed the decision: Board Certified Orthopedic Surgery

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

☐ Overturned (Disagree)
☑ Upheld (Agree)
☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)
XXXX, who was diagnosed with adhesive capsulitis of the right shoulder (M75.01). XXXX sustained an injury on XXXX, when XXXX was working on a XXXX.

XXXX for an orthopedic follow-up. XXXX presented four months status post arthroscopic right rotator cuff repair and right superior labral anterior-posterior (SLAP) repair. The pain was 6/10. XXXX stated XXXX shoulder felt stiff. On examination, the BMI was XXXX. Peripheral vascular pulses were 2+ bilaterally, and capillary refill was less than 3 seconds. Examination noted range of motion of forward flexion 0 to 90 degrees and 0 to 85 of abduction.

The treatment to date included medications, physical therapy, injections, home exercise program and surgical intervention (rotator cuff repair, and SLAP repair).

An MRI of the right shoulder dated XXXX showed near full thickness tear of the rotator cough, which appeared to be acute. Abnormal thickness of the supraspinatus tendon was noted, suspicious for a remote injury.

Per a utilization review decision letter dated XXXX, the request for manipulation under anesthesia of the right shoulder (CPT 23700) was denied XXXX with the following rationale: "According to the Official Disability Guidelines manipulation under anesthesia for the shoulder is currently under study, and not recommended. Additionally, there was a lack of clinical documentation provided for review with current subjective complaints, or objective findings to

sufficiently warrant this request. As such, the request for manipulation under anesthesia, right shoulder is noncertified."

Per a reconsideration review decision letter dated XXXX, the appeal that was received on XXXX was reviewed. It was determined that the request still did not meet medical necessity guidelines. The prior decision to deny the right shoulder manipulation under anesthesia was upheld by XXXX with the following rationale: "The Official Disability Guidelines recommend manipulation under anesthesia after failure to respond after a minimum 6 months of conservative treatment including physical therapy, corticosteroid injection, and nonsteroidal anti-inflammatory drugs. Passive shoulder flexion AND/OR abduction is less than 130 degrees. There is no documentation to support the patient failed a minimum of 6 months conservative treatment including physical therapy, corticosteroid injection, and nonsteroidal anti-inflammatory drugs. Therefore, the request for right shoulder manipulation under anesthesia (MUA) is noncertified."

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

The ODG recommend manipulation under anesthesia of the shoulder after failure to respond to a minimum of six months of conservative treatment including physical therapy, corticosteroid injection, and nonsteroidal anti-inflammatory drugs. The provided documentation reveals persistent right shoulder stiffness approximately four months out from an arthroscopic rotator cuff repair and SLAP repair despite postoperative physical therapy; however, while there is persistent restricted range of motion, there is objective improvement in range of motion between the office visits from XXXX. Given the ODG recommendation for a minimum of six months of conservative treatment, the injured worker only being four months out from surgery, and evidence of some objective improvement in range of motion, the request for right shoulder manipulation under anesthesia is not medically necessary.

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
- ☐ AHRQ-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
  - ODG-Shoulder Chapter
  - Manipulation under anesthesia (MUA)

Recommended as indicated below, only for primary adhesive capsulitis following failure of conservative management for at least 6 months. Poorer outcomes of manipulation under anesthesia (MUA) following shoulder surgery do not justify recommendation.
See also Surgery for adhesive capsulitis. See the Low Back Chapter for Low Back , where MUA is not recommended in the absence of vertebral fracture or dislocation; and the Knee Chapter in the Knee, where MUA is recommended for treatment of arthrofibrosis and/or following total knee arthroplasty.

ODG Indications for Surgery™ -- Manipulation under anesthesia:

Criteria for MUA with or without arthroscopic capsular release require ALL of the following:

1. Conservative Care: Failure to respond after a minimum 6 months of conservative treatment including physical therapy, corticosteroid injection, and nonsteroidal anti-inflammatory drugs.
2. Subjective Clinical Findings: Patient is capable and willing to strictly follow a post-operative rehabilitation protocol; AND has disabling pain and stiffness which significantly limits shoulder function.

3. Objective Clinical Findings: Passive shoulder flexion AND/OR abduction is less than 130 degrees.

- ☐ 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)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.