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Notice of Independent Review Decision

DATE OF REVIEW: NOVEMBER 26, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed outpatient EUA/MUA left shoulder (23700)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

REVIEW OUTCOME

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

- Upheld (Agree)
- XX Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

| Primary Diagnosis | Service being Denied | Billing Modifier | Type of Review | Units | Date(s) of Service | Amount Billed | Date of Injury | DWC Claim# | IRO Decision |
|-------------------|----------------------|------------------|----------------|-------|--------------------|---------------|----------------|---------------|--------------|
| 726.0 | 23700 | | Prosp | 1 | | | | 99L0000625718 | Overturn |
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TDI-HWCN-Request for an IRO- 19 pages

Respondent records- a total of 53 pages of records received to include but not limited to:

TDI letter 11.6.12; xxxxx letter 10.8.12, 11.6.12; xxxxx record; records, Dr XXXX 1.27.12-8.31.12; XXXX xxxxx 9.12.12; Rehab record 8.31.12; record 6.22.12-7.12.12; letter from PT 7.25.12; radiology report 9.27.11

Requestor records- a total of 26 pages of records received to include but not limited to: PHMO Notice of an IRO; TDI letter 11.6.2012; records , Dr. 1.27.12-10.15.12; xxxxx record 9.12.12; xxxxx 8.31.12; radiology report 9.27.11

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with a copy of the radiology report . This study of the left shoulder noted no acute fracture or dislocation. This was noted to be a normal shoulder.

The next note is an orthopedic clinic progress note dated January 27, 2012. The diagnoses listed were a post traumatic impingement syndrome, a left shoulder acromioclavicular joint injury, and a left shoulder girdle myofascial pain syndrome. It was noted that this was a follow-up evaluation and that the injured employee had completed some physical therapy. It was noted there was tightness in his neck and additional physical therapy was sought. The physical examination noted the left upper extremity to be in a long arm mitten cast. A positive impingement sign was noted as well as tenderness over the acromioclavicular joint. Additional physical therapy was prescribed.

At follow-up on April 2, 2012, it was noted that the injured employee had a healing soft tissue flap and split thickness skin graft which was healing well. There were no overlying skin changes at the shoulder. The range of motion was noted to be 180°. There was a positive impingement sign and tenderness over the acromioclavicular joint. There was a negative O'Brien's test. Continued physical therapy and a return to work in a light duty status were noted.

The May 14, 2012, note indicated that the wounds on the left were well healed and that there were skin grafts also well healed. There were some noted flexion contractures of the hands with an inability to fully extend his fingers. There was an inability to fully pronate or supinate the elbow. Shoulder flexion was 150° and abduction was 130°. It was determined that with regard to the shoulder, the injured employee was at maximum medical improvement.

The injured employee continued to do well; however, in July, there was an increase in symptomology and additional physical therapy was outlined. It is now noted, from the visit of August 31, 2012, that forward flexion was 90° actively, and 130° passively. Similar findings were noted for abduction. An equivocal O'Brien's test is noted. Dr. suggested that there was a capsulitis and a manipulation under anesthesia was recommended. This was augmented with additional physical therapy to the shoulder.

The preauthorization request was not certified by, M.D. anesthesiologist.

A follow-up orthopedic clinic note, dated October 15, 2012, noted left shoulder pain and stiffness. The report reflects that additional physical therapy had been denied and that this limited the injured employee to a self-directed program. Dr. felt that the manipulation under anesthesia would be beneficial. The left upper extremity range of motion was limited to painful motion alone. There was 115° of flexion reported.

A reconsideration of the request for a manipulation under anesthesia was completed by D.O. orthopedic surgeon. The request was not certified. Dr. noted that active shoulder flexion was 90°, passive was 130°; abduction was active to 90° and passively to 120°. The issues around this non-certification appear to be a lack of a complete documentation, a perceived lack of compliance with home exercise program, a lack of a radiologist analysis of the imaging studies and a lack of a complete set of the physical therapy records.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

As noted in the Division mandated Official Disability Guidelines the standards for an MUA are: 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 anesthesia 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 anesthesia (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](#)) See also the [Low Back Chapter](#), where MUA is not recommended in the absence of vertebral fracture or dislocation.

Based on the records presented, there is an advancing decrease in shoulder flexion and abduction. Approximately 90° of abduction is currently noted. Thus, this requirement appears to have been met. Therefore, when noting the advancing decrease in range of motion, the physical therapy sessions currently completed, and the physical examination findings of the requesting provider, tempered by the above listed parameters noted; this procedure should be pursued. Therefore, I am overturning the previous determination and endorsing this procedure.

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

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN
ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES