

**IRO REVIEWER REPORT - WC**

---

**DATE OF REVIEW:**            03-17-07

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Durable Medical Equipment – HCPCS Code E0936 Shoulder Passive Motion Device (CPM) for service dates 01-29-07 thru 02-20-07 (post-operatively).

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

Certified by the American Board of Orthopaedic Surgery  
General Certificate in Orthopaedic Surgery

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld Overturn
xx-xx-xx	xxxxxx-xxxxxxWC-01	Prospective	840.4	E0935	Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Determination Notices dated 02-15-07 and 03-8-07  
Appeal letter dated 02-16-07  
Prescription and Letter of Medical Necessity – Surgery Date 01-29-07  
Letter dated 01-16-07  
Physician letter recommending the S.C.O.I. brace dated 01-16-07  
Physical Therapy Evaluation Reports 01-02-07 and 02-07-07  
Follow Up Examination on 01-09-07  
Therapy Prescription Form dated 12-05-06

**PATIENT CLINICAL HISTORY [SUMMARY]:**

xx-xx-xx Date of Injury: Patient's arm was pulled in a machine  
11-29-06 MRI with Gadolinium: Chronic mild Hill Sachs lesion. No evidence of Rotator cuff tearing, labral tearing, nor Bankart lesion  
12-05-06 Physician order for physical therapy for 3x/week for 4 weeks due to adhesive capsulitis and impingement  
01-02-07 Physical therapy (PT) – 9 visits {12-07-06 to 01-02-07}. Pain lateral shoulder and over AC joint  
01-09-07 Follow-up visit: Hill Sachs lesion. Injected 4 weeks ago. Doing PT. Pain with impingement testing. Neither x-ray nor MRI. Home Exercise Program  
01-16-07 Request for SCOI brace  
01-29-07 Physician scheduled for outpatient surgery: Right shoulder scope, subacromial decompression and possible labral repair. {Note: no operative note included in the submitted records}  
02-07-07 PT evaluation report: "right scope with labral repair". Treatment Plan: HP/ES. Therex PROM and AAROM  
02-09-07 Physician request for outpatient PT 3x/week for 4 weeks

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

I found no record that neither rotator cuff nor labral repair of the right shoulder was performed on this patient. There is documentation of "mild Hill Sachs lesion" and "Adhesive capsulitis" noted by the treating physician but no definite rotator cuff tear. The physician submitted support for the use of a CPM is mainly for rotator cuff repairs and not for labral lesions.

**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)