



Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 09/07/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Eight week rental of JAS shoulder device

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Orthopedic Surgery, specializing in hand surgery.

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

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

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
7260			<i>Prosp.</i>	8	07/22/09-09/27/09				<i>Upheld</i>

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment
2. Letters of denial, 07/20/09, 07/27/09, 07/31/09 including criteria used in denial
3. Correspondence from legal representative and carrier dated 08/31/09
4. Independent Medical Evaluation, 07/22/09
5. Operative report and hospitalization documentation 02/10/09
6. Orthopedic assessment, followups, and correspondence, 05/12/09, 06/22/09, and 06/26/09 and 07/29/09
7. Evaluation and treatment documentation, 01/20/09 through 08/01/09

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient suffered a work-related injury to his shoulder. He suffered a massive rotator cuff repair that did not respond to conservative care. He was treated with arthroscopic rotator cuff repair and minimal acromioplasty. Postoperatively the patient suffered from severe weakness and loss of range of motion that did not respond to extensive physical therapy. A JAS shoulder device was requested to increase range of motion in this patient.

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

Although JAS static progressive devices are helpful in many patients with severely frozen shoulder adhesive capsulitis, this is a little more complex than that. This patient has had a massive rotator cuff repair with postoperative MR arthrogram that shows it is intact. However, an Independent Medical Examination confirmed that the postoperative MRI scan shows impingement from hypertrophic acromioclavicular joint, and the patient is symptomatic at that joint. I therefore agree with the Independent Medical Examiner's opinion that this patient would most likely benefit from another course of treatment. I do not believe that

the JAS external rotaiton device would be medically reasonable and necessary at this point in this patient's care.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
 - Rockwood and Matsen's shoulder textbook
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)