

MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: August 24, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

SEWHO ABDUCT PSTN THOR CMPNT&S CPT L3973 (shoulder turnbuckle orthosis device)

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

M.D., Board Certified in Orthopedic 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)

The requested equipment, SEWHO ABDUCT PSTN THOR CMPNT&S CPT L3973 (shoulder turnbuckle orthosis device), is medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 7/25/11.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 8/1/11.
3. Notice of Assignment of Independent Review Organization dated 8/1/11.
4. Letter from dated 7/25/11.
5. Prescription dated 6/2/11.
6. Progress Notes from MD dated 1/27/11, 2/7/11, 3/7/11, 4/4/11, 5/2/11, 5/31/11,
7. PT Outpatient Evaluation/Daily Notes dated 2/14/11, 3/4/11, 3/21/11, 4/13/11, 4/25/11, 4/27/11, 5/11/11, and 6/6/11.
8. EZ Shoulder Turnbuckle Orthosis Product Description with Bibliography.
9. Professional Testimonials.
10. Patient Testimonials.
11. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who has requested authorization for SEWHO ABDUCT PSTN THOR CMPNT&S CPT L3973 (shoulder turnbuckle orthosis device). The Carrier has denied this request indicating that the requested equipment is not medically necessary for treatment of the patient's shoulder pain. The medical documentation indicates that the patient presented on 1/27/11 and reported shoulder pain. On this date, the medical records noted that the patient sustained an injury to her right shoulder when she was pulling a heavy mobile cart in xx/xx. She reported that she felt a sharp pain in the posterior aspect of the right shoulder in the scapular region. The patient has received physical therapy. However, she continues to have pain. A right shoulder MR arthrogram documented a partial intrasubstance tear of the supraspinatus tendon and osteoarthritis. The patient was discharged from physical therapy on 5/11/11 after receiving 16 treatments. On 5/31/11, the patient's external rotation was 88 degrees and internal rotation was 35 degrees. The patient's provider has recommended a shoulder turnbuckle orthosis device.

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

Upon review of the medical records provided, there is sufficient support for the shoulder turnbuckle orthosis device in this patient's case. The Official Disability Guidelines (ODG) indicate that a mechanical device for joint stiffness may be considered appropriate for up to eight weeks when used for specific conditions. These conditions include joint stiffness caused by

immobilization, established contractures when passive range of motion is restricted, healing tissue that can benefit from low-intensity tension, or when used as an adjunct to physical therapy within three weeks of manipulation or surgery to improve range of motion. In this patient's case, she has an established contracture of the shoulder joint with restricted range of motion, as noted in the submitted records. According to the ODG, appropriate candidates include patients with connective tissue changes as a result of traumatic and non-traumatic conditions or immobilization, causing limited range of motion. In this patient's case, there is evidence of a partial supraspinatus tear. This patient is likely to benefit from constant low-intensity tension. As such, SEWHO ABDUCT PSTN THOR CMPNT&S CPT L3973 (shoulder turnbuckle orthosis device) is medically necessary for treatment of the patient's condition.

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)