

MRI

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Notice of Independent Review Decision

DATE OF REVIEW: 7/4/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of post-operative massage therapy to the right shoulder 1 time per week for 4 weeks.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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 reviewer agrees with the previous adverse determination regarding the prospective medical necessity of post-operative massage therapy to the right shoulder 1 time per week for 4 weeks.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY (SUMMARY):

The female was injured on xx/xx/xx. She sustained a torn rotator cuff of the right shoulder, associated with lifting rocks. She underwent surgical repair on 2/4/11, along with a debridement and decompression procedure. Post-operatively, she developed adhesive capsulitis. As of the most recent PT records, the patient/claimant has had a persistent and painfully stiff shoulder with functionality restrictions. In addition to ongoing PT, there is an AP consideration (from a Dr.) for massage treatments to the affected shoulder. On 5/20/11, the AP noted improved shoulder motion, including 120 degrees of forward flexion. Prior records (including from 4/22/11) were reviewed. Massage therapy was felt applicable/indicated, in particular "when patients have reached a plateau."

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

Applicable (ODG) criteria do not support passive modalities such as massage, and, outcomes are equivocal at best. Guidelines note "conflicting evidence of the

efficacy of massage in the treatment of shoulder pain.” In addition, “Physical modalities, such as massage.....are not supported by high quality medical studies.” Therefore, the prior denial(s) remain appropriate at this time, and, should be upheld.

Reference: ODG- Shoulder/Massage, “Under study. There is conflicting evidence of the efficacy of massage in the treatment of shoulder disorders. (Philadelphia, 2001) A recent meta-analysis also concluded there is conflicting evidence of the efficacy of massage in the treatment of shoulder pain. (Verhagen-Cochrane, 2004) Physical modalities, such as massage, diathermy, cutaneous laser treatment, ultrasonography, transcutaneous electrical neurostimulation (TENS) units, and biofeedback are not supported by high quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms, depending on the experience of local physical therapy providers available for referral. See also Deep friction massage.”

The requested modality is not supported via the medical records and high quality studies. Therefore, the requested service is found to be not medically necessary at this time.

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)**