

# True Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Aug/15/2013

**IRO CASE #:**

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

Appeal Urgent ERMI shoulder flexionater X 30 day rental

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

Board Certified Orthopedic Surgeon (Joint)

**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 medical necessity exists for each health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 07/09/13, 06/07/13

Letter dated 07/24/13

Encounter summary dated 07/10/13, 05/20/13, 04/10/13, 03/13/13, 02/20/13

Plan of care dated 05/13/13, 02/22/13

Daily note dated 07/03/13

Reference material regarding ERMI shoulder flexionater

Operative report dated 05/02/13

Progress note dated 05/28/13, 04/09/13

Initial evaluation dated 02/22/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male whose date of injury is xx/xx/xx. The patient reports that he slipped while getting into his truck. The patient braced the car door placing an extension and ER strain on the extremity. The patient subsequently underwent right shoulder arthroscopy with lysis of adhesions, distal clavicle resection and subacromial decompression on 05/02/13 followed by 24 postoperative physical therapy visits. Encounter summary dated 07/10/13 indicates that there is no weakness, no numbness and tingling, no swelling, no redness, no warmth, no popping/clicking, no grinding and no buckling. The patient is noted to be working modified duty. Range of motion is as expected and improved with abduction to 130, forward flexion to 130, internal rotation to below sacrum and external rotation 25 degrees. Strength is noted to be improved.

Initial request for ERMI shoulder flexionater x 30 day rental was non-certified on 06/07/13 noting that per telephonic consultation, Ms. agrees that the patient has been making progression in regards to his range of motion. She states that the patient will be continued on his physical therapy treatment at this time and will be re-evaluated on 07/10/13 for indications for additional treatment measures. The denial was upheld on appeal dated 07/09/13 noting that it was noted that the patient has made progress in range of motion of the right shoulder. However, the patient has not completed their full physical therapy program, so its efficacy is not known at this time.

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

The patient is status post right shoulder arthroscopy with lysis of adhesions, distal clavicle resection and subacromial decompression on 05/02/13 followed by 24 postoperative physical therapy visits. Per note dated 07/10/13, range of motion is as expected and is improved. Strength is also noted to be improved. The Official Disability Guidelines Shoulder Chapter reports that flexionaters are under study for adhesive capsulitis. No high quality evidence is yet available. A study of frozen shoulder patients treated with the ERMI Shoulder Flexionater found there were no differences between the groups with either low or moderate/high irritability in either external rotation or abduction (glenohumeral abduction went from about 52% to 85% in both groups over a 15-month period), but there was no control group to compare these outcomes to the natural history of the disease. According to other studies, outcomes from regular PT and the natural history of adhesive capsulitis are about as good. As such, it is the opinion of the reviewer that the request for urgent ERMI shoulder flexionater x 30 day rental is not recommended as medically necessary.

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

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

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**