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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jan/31/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 42 day rental (11/27 to 01/16/12) of shoulder CPM unit for the left shoulder

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O. Board Certified 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that this request for 42 day rental (11/27 to 01/16/12) of shoulder CPM unit for the left shoulder does not meet guideline recommendations and is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical note dated 12/04/12
Previous utilization reviews dated 12/18/12 and 01/09/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his left shoulder. The clinical note dated 12/04/12 details the patient having undergone a SLAP repair with subacromial decompression and a rotator cuff repair. Upon exam, no swelling, tenderness, or infection were noted at the operative site. The patient was noted to have limited active and passive range of motion. The patient was noted to be doing well 1 week post-op following the SLAP repair.

The previous utilization review dated 12/18/12 resulted in a denial for a 42-day rental of a CPM unit for the left shoulder secondary to a lack of recommendation by the Official Disability Guidelines.

The utilization review dated 01/09/13 also resulted in a denial secondary to the device not being specifically recommended by Official Disability Guidelines.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient having undergone surgical intervention at the left shoulder. The Official Disability Guidelines do not specifically recommend a continuous passive motion machine for the shoulder as there is a lack of evidence supporting the efficacy and safety. Additionally, previous trials have yielded only moderate results regarding an increase in

function and a decrease in pain regarding the use of a CPM at the shoulder. Given the lack of supporting evidence regarding the safety, efficacy, and functional outcome with the use of a CPM at the shoulder, it is the opinion of the reviewer that this request for 42 day rental (11/27 to 01/16/12) of shoulder CPM unit for the left shoulder does not meet guideline recommendations and is not medically necessary.

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

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE

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)