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Notice of Independent Review Decision

Date notice sent to all parties: 6/24/2013

IRO CASE #: 46281

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

30 days rental of ERMI shoulder flexionator, CPT code E1399

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

Texas Licensed Board Certified Orthopedic Surgeon

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 of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. 4/26/13 and 5/16/13 Denial letters and rationale
2. 3/27/13 Operative Report
3. 6/11/13 and 4/25/13 notes
4. 3/27/13 Prescription for Flexionator
5. 3/29/13 Letter of medical necessity
6. 3/26/13-4/19/13 Physical Therapy notes
7. ERMI Shoulder Flexionator flyer
8. IRO Request

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant has been well documented to have undergone surgical intervention at the level of the left shoulder. This included at approximately the age of 54 for injury sustained on 08/21/2012. Reportedly she had been throwing a heavy bag and injured her left shoulder. The claimant was treated non-operatively and then operatively with a left shoulder arthroscopic subacromial decompression with rotator cuff repair on 12/10/2012. The claimant developed some postoperative significant pain and suboptimal motion and underwent a manipulation under anesthesia and a cortisone injection in March 2013. The operative summaries were reviewed. The claimant was also prescribed in conjunction with treatment for the diagnosed adhesive capsulitis in addition to physical therapy and medications, the use of an ERMI Shoulder Flexionator. The claimant's motion had improved as of 04/01/2013 to abduction of 115 degrees with flexion of 135 degrees. The letter of medical necessity from the treating provider dated 03/29/2013 discussed the medical indication for the flexionator as part and parcel of the treatment for the claimant in particular for adhesive capsulitis. Denial letters have discussed the postoperative progress and the lack of high quality studies with regards to flexionator as documented in the ODG guidelines.

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

The applicable ODG criteria and documentation submitted for review overall do not support the medical necessity of a 30-day rental of the ERMI Shoulder Flexionator with CPT Code E1399. The claimant did have not insignificant postoperative progression in despite of being relatively slow overall. In addition, the applicable ODG criteria/guidelines do not evidence that the flexionator is other than "under study." The medical literature at large has not evidenced large volume long-term studies with regards to the flexionator in particular with regards to efficacy and/or for that matter safety. Therefore, at this time the medical reasonableness and/or necessity of the request has not been established based on the applicable ODG criteria referenced below.

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)**