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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/05/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: shoulder flexionater rental for 3 months

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D. 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 health care service in dispute. It is the opinion of the reviewer that the request for shoulder flexionater rental for 3 months is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 04/29/13, 04/12/13
Letter of medical necessity dated 03/26/13
Initial evaluation dated 10/23/12
Encounter summary dated 03/04/13
Daily note dated 03/26/13, 04/16/13, 03/05/13
Addendum to daily note dated 04/23/13
Report of procedure dated 09/05/12
Re-evaluation dated 02/21/13
Plan of care dated 02/21/13, 11/27/12
Office note dated 05/25/12, 06/04/12, 07/16/12, 08/06/12
Radiographic report dated 05/15/12
MRI left shoulder dated 05/15/12

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. On this date the patient lifted a coffee pot and service cart during a xx and reported right shoulder injury. The patient underwent right shoulder arthroscopic rotator cuff repair, biceps tenodesis and subacromial decompression on 09/05/12. Letter of medical necessity dated 03/26/13 indicates that the patient has attended more than 4 months of postoperative physical therapy and has been extremely slow to progress with her right shoulder range of motion. This continued loss of motion has developed into adhesive capsulitis. Per daily note dated 04/16/13, the patient has completed 41 physical therapy visits. Right shoulder AROM is flexion 125, abduction 125, external rotation 60 and internal rotation 50 degrees.

Initial request for shoulder flexionater rental for 3 months was non-certified on 04/12/13

noting that Official Disability Guidelines state flexionaters are under study for adhesive capsulitis. There is no high-quality evidence available. According to studies, outcomes from regular physical therapy and the natural history of adhesive capsulitis are about as good. The physician feared that the continued loss of motion had developed into adhesive capsulitis. Untreated, the physician stated the condition could lead to overcompensation to other joints causing further injury and/or surgery. However, Official Disability Guidelines indicate that outcomes from regular physical therapy were just as good as the controlled study that used the flexionater. The patient would likely benefit from continued use of physical therapy as well as home exercise program in order to continue to make gains with functional mobility and decreased pain.

The denial was upheld on appeal dated 04/29/13 noting that there are no additional medical records available for review. The previous reviewer's non-certification is supported. The guideline state use of the flexionater is under study for adhesive capsulitis and no high-quality evidence is yet available.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient underwent right shoulder arthroscopic rotator cuff repair, biceps tenodesis and subacromial decompression on 09/05/12 and has completed at least 41 postoperative physical therapy visits to date. The submitted records indicate that the patient has been extremely slow to progress with her right shoulder range of motion, and the patient was recommended to utilize a flexionater. However, the Official Disability Guidelines state that these devices 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. 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 shoulder flexionater rental for 3 months is not recommended as 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 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)