



# MedHealth Review, Inc.

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## Notice of Independent Review Decision

**DATE NOTICE SENT TO ALL PARTIES:4/2/14**

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of purchasing a left shoulder orthosis abduction positioning airplane design and cryotherapy rental for 7 days.

### **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 purchasing a left shoulder orthosis abduction positioning airplane design and cryotherapy rental for 7 days.

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

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed:

**PATIENT CLINICAL HISTORY [SUMMARY]:**

was injured on xx/xx/xx. The claimant was diagnosed with a shoulder sprain. A left shoulder MRI dated December 16, 2013, revealed rotator cuff tendinopathy with acromioclavicular (AC) joint osteoarthritis. On February 10, 2014, there was ongoing shoulder pain despite physical therapy, activity restriction and medications. Left shoulder (positive) exam findings included tenderness at various segments, along with positive belly press, lift-off, Speed's and O'Brian's tests. There was a consideration for rotator cuff repair with possible proximal bicep tenodesis, extensor debridement, synovectomy, and treatment as indicated.

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

Cryotherapy is ODG-supported for up to seven days post-op. This is to treat the expected significant post-op pain and inflammation. However, applicable ODG criteria typically would only support such a requested abduction positioning/airplane-type design splint post an open repair of large and massive rotator cuff tears. This is due to the significantly increased risk of post-op stiffness and adhesive capsulitis/"frozen shoulder" in such cases, unlike in this patient's clinical condition and proposed type of arthroscopic surgical treatment. The abduction device is therefore not guideline supported. Therefore since the requests are concurrent; they are considered not reasonable and medically necessary. Since both are not supported overall, the aggregate of requests is not supported at this time.

Reference:ODG Shoulder Chapter: Continuous-flow Cryotherapy:

Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated.

Postoperative abduction pillow: Recommended as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. Due to not meeting the ODG, this request is 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)**