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**NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE NOTICE SENT TO ALL PARTIES:** Aug/13/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** shoulder flexionater 30 day rental

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** DO, 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 the request for shoulder flexionater 30 day rental is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. The mechanism of injury is described as a fall. The patient underwent left shoulder rotator cuff repair on 05/12/14 and rotator cuff repair for a large tear in February 2015. Office visit note dated 05/14/15 indicates that the patient is 12 weeks post op rotator cuff repair and still improving. Medications are listed as acetaminophen-codeine, tramadol, Robaxin, cyclobenzaprine, and Norco. Left shoulder passive range of motion is flexion 140, supraspinatus 100, internal rotation to sacrum. Strength is 4/5 supraspinatus. Office visit note dated 05/20/15 indicates that the patient has progress in terms of pain reduction and swelling, but he has developed severe arthrofibrosis in his left shoulder. He is currently at 74 degrees of abduction and 60 degrees of external rotation. Follow up note dated 06/25/15 indicates that the left shoulder is doing well. There is less pain, but he is still having problems with overhead activity. Left shoulder passive range of motion is flexion 140, supraspinatus 120 degrees. Supraspinatus strength testing is 4/5.

Initial request for shoulder flexionater 30 day rental was non-certified on 06/04/15 noting that the use of the flexionater or other continuous passive motion machines for the shoulder has not been proven in peer reviewed scientific studies to be more effective than standard postoperative physical therapy. Appeal letter dated 06/29/15 indicates that the device has been prescribed as treatment for the patient's left shoulder to help improve his range of motion. The patient underwent arthroscopic rotator cuff repair of the left shoulder on 02/03/15. The patient's recovery was not successful after standard treatment. Passive range of motion measurements are at 107 degrees of abduction (was 92) and 63 degrees of external rotation (was 48) [see PT notes 5/13/15, 6/17/15].

The denial was upheld on appeal dated 07/07/15 noting that the shoulder chapter of ODG states flexionaters are "under study for adhesive capsulitis. No high quality evidence is yet available." According to studies, outcomes from regular PT and the natural history of

adhesive capsulitis are about as good. In addition, it was indicated that the patient has had 32 sessions of PT; however, there was no mention that the patient participated in a home exercise program. The patient should be well-versed in a home exercise program at this time. There was no documentation stating that the patient had failed conservative treatment with PT and a home exercise program.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient underwent left shoulder rotator cuff repair on 05/12/14 and rotator cuff repair for a large tear in February 2015 and has completed at least 32 physical therapy visits to date. The submitted records indicate that the patient still has not regained shoulder range of motion and has difficulty with overhead activities. The patient has been recommended to utilize a flexionater device to help regain his range of motion. However, the Official Disability Guidelines note that flexionaters are under study for adhesive capsulitis. There is no high quality evidence 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 shoulder flexionater 30 day rental is not recommended as medically necessary and the prior denials are upheld.

**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)