

MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

Notice of Independent Review Decision

Reviewer's Report

DATE OF REVIEW: September 4, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

1 DME: end range motion improvement (ERMI) shoulder flexionater for the left shoulder, rental for 30 days, as an outpatient.

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

M.D., Board Certified in Physical Medicine and Rehabilitation with Sub-specialty Certification in Pain Medicine.

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)

I have determined that the requested 1 DME: end range motion improvement (ERMI) shoulder flexionater for the left shoulder, rental for 30 days, as an outpatient is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury on xx/xx/xx. The patient is status post left shoulder rotator cuff repair. On 5/06/15, the physical therapy note indicated that the patient has had a cumulative total of 15 visits to date. The patient reported performing home exercise daily. The

physical examination with passive range of motion was noted with flexion at 110 degrees and abduction at 95 degrees. His current pain was noted at 4/10. Case management notes indicated that the patient has been utilizing a range of motion improvement flexionator device and significant gains have been made. The left shoulder was noted to have 82 degrees with abduction and this had improved to 115 degrees after several months of using the device. It was also noted that the device is used in the home to augment physical therapy and that the patient has completed 34 sessions of physical therapy per case management notes. A request has been submitted for 1 DME: end range motion improvement (ERMI) shoulder flexionator for the left shoulder, rental for 30 days, as an outpatient.

The URA indicates that the requested device is not medically necessary. Specifically, the initial denial noted that the provider indicated that he did not order the requested device and it was not necessary for the patient. On appeal, the URA noted that there is not clinical indication presented to support the continued use of the device. Per the URA, a home exercise protocol is all that is clinically indicated.

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

The patient is status post left shoulder rotator cuff repair and he is noted to be utilizing the ERMI shoulder flexionator for an unspecified duration of time. According to the Official Disability Guidelines, shoulder flexionators/extensionators are under study for the diagnosis of adhesive capsulitis. However, there is no high quality evidence available to support the device, and other studies indicate that regular physical therapy in the natural history of adhesive capsulitis is about as beneficial as using the device. Although the clinical documentation indicated that this patient has made significant improvement in regard to abduction and elevation from previous monthly usage, there is a lack of documentation in regard to the total duration of time the patient has been utilizing the machine. Moreover, there was a lack of a clear rationale to indicate the continued use of an ERMI device over a home exercise program for continued maintenance. In addition, the clinical documentation submitted for review failed to indicate the patient had adhesive capsulitis based on physical examination findings or diagnosis. Based on the above, the requested device is not medically indicated for the treatment of this patient.

Therefore, I have determined the requested 1 DME: end range motion improvement (ERMI) shoulder flexionator for the left shoulder, rental for 30 days, as an outpatient is not medically necessary for treatment of the patient's medical condition.

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 JUDGMENT, 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)