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Date notice sent to all parties: 03/05/19

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

ERMI XX XX XX rental for XX days

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

Board Certified in Orthopedic Surgery
Fellow of the American Academy of Orthopedic Surgeons
Fellow of the American Association of Orthopedic Surgeons
Diplomate of the American Board of Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)

X 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.

ERMI XX XX XX rental for XX days – Overturned

PATIENT CLINICAL HISTORY [SUMMARY]:

XX examined the patient on XX. XX had XX a XX and felt sharp pain in the XX XX. XX had undergone therapy and an MRI showed a full thickness 1.5 x 1.5 XX without fatty infiltration and no atrophy. Surgery was recommended and on XX, XX performed arthroscopic XX XX XX repair of full thickness XX tear, XX decompression, and extensive XX debridement. XX then reevaluated the patient on XX and XX. XX was an arm XX and had pain with certain movements. XX noted XX had one issue while XX against instruction that jerked XX XX and another out of the XX that XX felt a pop. On XX, it was noted XX had been going to therapy XX to XX times per week with improvements. Forward flexion was 90 degrees and passively, it was 120 degrees. Abduction was 70 degrees. XX more sessions of therapy were recommended. As of XX, XX had been doing well with improvement pain and range of motion. Additional therapy was recommended and XX would follow-up in XX XX with the plan of being released. The patient was seen on XX, but this was a poor copy. On XX, a prescription was written for an ERMI XX XX for XX days use. Corresponding literature was also provided. A prior authorization request was submitted on XX for the XX XX unit. On XX, the XX XX ERMI XX device for XX days was denied. On XX, a request for reconsideration was submitted by XX. On XX, another denial was provide per the peer review report.

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

The patient is a XX-year-old XX who reportedly developed XX XX pain after XX a XX. XX has subsequently undergone arthroscopic XX XX repair, XX decompression, and XX debridement by XX on XX. The patient was placed in a XX XX repair protocol and after a period of immobilization began XX therapy. It appeared that XX did make initial progress with therapy and then plateaued. The XX therapy note of XX documented that the patient was not progressing with therapy and appeared to be regressing secondary to a component of adhesive XX, or frozen XX. XX then has requested the ERMI XX XX XX for XX days. XX, XX, an orthopedic surgeon, non-certified the request on initial review on XX. XX decision was upheld on reconsideration/appeal by XX, an orthopedic surgeon. Both reviewers attempted peer-to-peer without success and based their opinions on the basis of the ODG. XX

While this device cannot be yet broadly recommended, it is an alternative option in conjunction with continued XX therapy if XX weeks of XX therapy alone has been clearly unsuccessful in adequately correcting range of motion limitations secondary to refractory adhesive XX, otherwise needing manipulation and/or XX. In this situation, it could be considered on a case-by-case basis for an initial XX week home rental in conjunction with XX therapy as an alternative to more invasive and costly surgical procedures. The ODG, as noted above, documents

no high quality evidence is yet available; however, it also notes it is an alternative option on a case-to-case basis in the setting of a potentially more invasive and costly surgical procedure. Therefore, the requested XX XX XX rental for XX days is appropriate and medically necessary and the previous adverse determinations should be overturned 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**

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X 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)**