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Notice of Independent Review Decision

APRIL 11, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

RIGHT SHOULDER CAPSULORRHAPHY, GLENOHUMERAL JOINT, ANY TYPE
MULTIDIRECTIONAL INSTABILITY

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

M.D. Board Certified in Orthopaedic 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 or not
medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Table of Disputed Services
Determination Letters: - 3/4/08; 3/17/08
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MRI Arthrogram Right Shoulder – 2/8/07

MRI Right Shoulder – 6/20/06
Operative Report – 7/21/06
Office Notes - M.D. – 7/3/06 – 2/25/08
Office Notes - Medical Centers – 6/16/06 – 7/10/06
ODG Guidelines

PATIENT CLINICAL HISTORY: SUMMARY OF EVENTS:

This case involves a xx year old female who injured her shoulder while lifting a box. She presented with shoulder pain and possible biceps pain and a catching sensation in her shoulder. The patient has had a previous right shoulder arthroscopy in the distant past with full recovery. An MRI demonstrated labral pathology and she was referred to Dr. Surgery was recommended. Patient underwent arthroscopic debridement of a small degenerative flat tear, removal of rupture sutures and radio frequency capsular shrinkage with subacromial bursectomy on 7/21/06. She was placed into a postoperative rehabilitation program. Approximately xx/xxxx, she re injured her shoulder when she slipped on some ice hyper extending her right shoulder causing increased pain. An MRI arthrogram was obtained and she was sent back into to physical therapy. She continued under conservative measures including home exercise program and a range of motion and strengthening program. On 11/28/07 she continued to complain of pain and Dr. felt she could have continued subtle instability. Because of persistent symptoms, on 2/25/08, he as recommended an open anterior capsular reconstruction. This procedure has been denied as medically unnecessary by the insurance company.

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

I disagree with the benefit company's decision to deny the requested services. ODG guidelines do not correctly address subtle instability as a cause of chronic shoulder pain. It really only talks about frank instability due to dislocations, and labral tears such as bankart lesion or slap lesions. This patient really has slap lesions and anterior labral pathology causing subtle instability and chronic pain. She has failed arthroscopic attempts at treatment. An open anterior capsulorrhaphy reconstruction is indicated for this patient. ODG guidelines do not adequately address this complex shoulder patient. This decision is based on my medical experience as an upper extremity fellowship trained orthopaedic surgeon as well as standard of care with regards to complex shoulder instability.

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)