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IRO CERTIFICATE

Notice of Independent Review Decision

July 21, 2008 (Amended 8/4/08)

JULY 21, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right Elbow Arthroscopy with Lateral Release

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

M.D. Board Certified in Orthopedic Surgery

REVIEW OUTCOME

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

X Upheld

(Agree)

Overtaken

(Disagree)

Partially Overtaken (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

Medical Determination Letters – 5/23/08, 6/11/08

Medical Determination Letters – 5/27/08; 6/13/08
X-Ray Interpretation: Right Elbow 2 views
Progress Report: M.D. - 4/9/08; 5/7/08
History & Physical: Orthopaedic Specialists – 5/21/08
Clinical Notes: – 2/25/08; 2/29/08; 3/12/08
ODG Guidelines

PATIENT CLINICAL HISTORY: SUMMARY OF EVENTS:

This case involves a female who injured her elbow at work while lifting heavy boxes. She developed lateral epicondylitis and was treated conservatively including wrist bracing, medications, activity modification as well as steroid injection. Steroid injection gave her complete relief of her pain, however, it reoccurred. Dr. has recommended arthroscopy with lateral release. This has been denied by the insurance company due to inadequate trial of conservative care.

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

I agree with the benefit company's decision to deny arthroscopy with lateral release. The patient has had excellent relief with the injection and has not failed 6 months of conservative care. Surgical release would not be medically necessary prior to a longer trial of conservative treatment. Criteria used in this decision is the ODG Guidelines as well as medical judgment and experience.

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)