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Notice of Independent Review Decision

**DATE OF REVIEW:** 12/12/09, amended 12/17/09

**IRO CASE #:**

Description of the Service or Services In Dispute (Amended)  
Left shoulder arthroscopic subacromial decompression with debridement.

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

Physician Board certified in 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)

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**

Adverse determination letters, 11/13/09, 11/12/09, 11/5/09  
Orthopedic reports 10/26/09, 8/24/09, Dr.  
X-ray left shoulder report 8/24/09  
MRI left shoulder report 6/23/09  
ODG guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient suffered an injury to the shoulder in xx/xx. This was followed by chronic shoulder pain. He was diagnosed with subacromial impingement syndrome. He was treated with physical therapy and received one steroid injection and received temporary relief. An MRI scan showed evidence of chronic impingement with supraspinatus tendinosis, no full thickness rotator cuff tear, and cystic change in the greater tuberosity region of the proximal humerus.

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

I disagree with the decision to deny the requested arthroscopic surgery. The denials were based on normal imaging findings. I completely disagree. This patient had obvious signs of impingement with supraspinatus tendinosis and cystic changes in the greater tuberosity. The patient failed adequate conservative care, and therefore the requested surgery is medically reasonable and necessary.

**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)