

Envoy Medical Systems, L.P.
1726 Cricket Hollow Dr.
Austin, TX 78758

PH: (512) 248-9020
FAX: (512) 491-5145
IRO Certificate

Notice of Independent Review Decision

DATE OF REVIEW: 9/25/09

IRO CASE #:

Description of the Service or Services In Dispute
repeat right shoulder arthroscopy w rotator cuff repair

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, 8/17/09, 8/4/09, 6/16/08, 11/9/07, 11/8/07, 7/15/08
Peer reviews 5/27/09, 1/9/08 and IR report 12/8/
Clinical notes DR. 2007-2009
Clinical ntes Dr. 2008-2009
Chiropractic notes 2007-2009
Arthrogram report 7/20/09
x-rays and arthrogram 12/21/07
DDE, Dr., 2/20/08, Dr. 11/25/08
MR arthrogram 8/19/08
Operative reports 8/28/08, 7/10/08
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient evidently has had bilateral shoulder arthroscopy with arthroscopic distal clavicle resections and acromioplasty. A door was slammed on the patient's right shoulder in xx/xx. Following conservative treatment, the patient underwent shoulder arthroscopy with arthroscopic acromioplasty, debridement and distal clavicle resection. Post operatively he continued to have pain, despite pain management efforts. Repeat MR arthrogram showed a defect in the supraspinatus, as well as post operative changes.

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

I disagree with the denial of the requested services. This patient has a partial rotator cuff tear in his original injury. This was treated with arthroscopic debridement, which sometimes is inadequate, and the lesion needs to be completed, and a follow-up rotator cuff repair performed. The records indicate that this is the case in this patient, and repeat arthroscopy and rotator cuff repair appear to be medically necessary. The ODG guidelines do not specifically address this, and this opinion is based on extensive clinical experience and the standard of care within the orthopedic surgery community.

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)