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Notice of Independent Review Decision

DATE OF REVIEW: 5/28/10

IRO CASE #:

Description of the Service or Services In Dispute
R shoulder acromioplasty and rotator cuff repair to include 23420

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:

X Upheld	(Agree)
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 3/11/10, 2/17/10, 5/7/10, 5/10/10
Radiology and MRI reports 3/4/10, 2/26/10
Progress notes, Dr. 4/30/10, 4/8/10, 3/5/10, 2/26/10,
Injury report xx/xx/xx
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who suffered a injury in xx/xx as the records are conflicting about the date and location of the injury. The patient had an MRI on 3/4/10, read as an incomplete tears versus tenosynovitis of the supra and infraspinatus tendons with a associated moderate fluid in the subacromial/subdeltoid bursae and subcoracoid bursa. The was diagnosed with rotator cuff tear, and right shoulder acromioplasty and rotator cuff repair were recommended.

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

I agree with the decision to deny the requested services, because there is confusion about the date and location of the injury. Also, according to the MRI, there is not a complete tear, and therefore, the patient might benefit significantly benefit from conservative treatment such as physical therapy and injections, which might resolve her problem without surgery. If the patient does not improve with conservative treatment, then surgery might eventually be indicated.

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)