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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 3/7/11

IRO CASE #:

Description of the Service or Services In Dispute
Left shoulder subacromial injection

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

Physician Board Certified in Physical Medicine and Rehabilitation

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, 2/3/11, 1/28/11
MRI left shoulder report 7/16/10
Clinical Notes, Orthopedics 4/2010 – 2/2011
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient fell from a truck in xx/xxxx. He sustained injuries in several areas, including a fractured right wrist, injury to the left shoulder, pain syndrome in the left knee. The left shoulder pain increased, and there was an initial subacromial injection to the left shoulder 5/4/10. Left shoulder symptoms persisted, however, which led to a 7/16/10 MRI that revealed a non-displaced fracture of the greater tuberosity of the humerus. The patient underwent a second shoulder injection 8/13/10. A third injection was requested and denied by the carrier. The patient has a history of myasthenia gravis, and is considered an increased risk for surgery.

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 services. This case and situation is considerably outside the paradigm of the ODG. The injury included a shoulder fracture, which is somewhat different from the usual bursitis, tendonitis alone. There is some increased anesthesia hazard with the myasthenia gravis. The second injection was in August 2010, six months ago. In continued effort to avoid surgery, a third injection is justified and necessary. There have not been enough

injection to cause “spontaneous rupture” worry. These are not “routine” injections, as referred to in the ODG guidelines quoted in the denial.

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)