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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 3/9/11

IRO CASE #:

Description of the Service or Services In Dispute
Left shoulder manipulation under anesthesia

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)
<input checked="" type="checkbox"/> 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, 1/25/11, 12/30/10
Clinical notes, postoperative period notes, 5/10 –2/11
MRI report 5/12/10
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is female who slipped and fell from a ladder, striking the left side of her back, left shoulder, and left knee. She had ongoing pain, and MRI revealed a complete rotator cuff tear, and she subsequently underwent left shoulder rotator cuff repair, and subacromial decompression. She underwent several months of physical therapy with very poor progress both clinically and at home, with ongoing pain syndrome, and decreased ROM.

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 resides outside the paradigm of the ODG. This is a traumatic injury with complete rotator cuff tear, and post surgical treatment. The patient has lost significant ROM recently. The 2/9/11 office note reported forward elevation of 90 degrees and abduction was 80 degrees. On 1/6/11, forward elevation was 120 degrees and abduction was 110 degrees. This is outside the ODG for Shoulder/manipulation under Anesthesia for the usual capsulitis, frozen shoulder syndrome.

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)