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IRO certificate #

Notice of Independent Review Decision

DATE OF REVIEW: 4/05/12

IRO CASE: #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Rt Shoulder MUA (manipulation under anesthesia) w/subacromial steroid injection
(CPT-23700); Post-op Physical Therapy 5x w/2wks (no codes provided)

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

Board certified in Physical Medicine & 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination & Reconsideration Letters, H/C, 3/13/12, 3/06/12,
Clinical Notes, MD, 02/21/12 – 11/14/11
Operative Rpt, Surgery Ctr, 11/07/11
Procedure 23700/26010, Orthopedic Grp., 12/20/11
Plan of Care & Progress, Sports Medicine & P/T, 1/27/12
Signed Scrip for ERMI Shoulder Flexionater (E1399), 2/03/12
ODG

PATIENT CLINICAL HISTORY [SUMMARY]

Patient is a female who, while at work, due to a fall, sustained an injury to her right shoulder. She was found to have a full thickness rotator cuff tear and had poor progress with physical therapy alone. She was followed and treated by Dr. and underwent right shoulder arthroscopy with cuff repair and debridement of scar tissue on 11/07/11.

Following, she had more conservative treatment, but had unsatisfactory range of motion gains and ongoing pain in the shoulder.

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

MUA, with concurrent subachromial steroid injection, followed with daily P/T x two weeks, has been requested. These have been denied. I disagree with the benefit company's decision to deny the requested services. The MUA and concurrent steroid injection into the joint is an appropriate request, as are the five treatments per week, for two weeks, for immediate daily physical therapy for range of motion.

There are multiple "outliers" in this case: 1) to base denial on chiropractic manipulation (see ODG) does not apply, and 2) ODG "steroid injection" guidelines are not referring to the joint injection at the time of MUA. The ODG physical therapy guidelines (and "fading of frequency" of treatments) does not apply here - versus the recommended intense daily 10 treatments immediately, post-op breakup of adhesions, etc. The postoperative recommended physical therapy treatments are recommended, as is the MUA with the concurrent steroid injection of the joint. To reiterate, I totally disagree with denial "based on strict ODG" in this case.

A 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 KNOWLEDGBASE
- 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)**