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**IRO Certificate #4599**

**Notice of Independent Review Decision**

**DATE OF REVIEW: 5/21/12**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

MR Arthrogram Rt Shldr (repeat), ICD-9/DSMV 727.61) CPT - MRIUE)

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

Physician Board Certified in Orthopaedic 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters/Reconsideration, 4/19/12, 4/05/12

Physical Therapy Notes, 3/06/12 - 1/19/12

Clinical Notes, 12/27/11, 12/14/11

Operative Report., 12/14/11

ODG

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient is a female who initially injured her right shoulder in xx/xxxx, while at work. According to an initial evaluation dated 1/9/12 by, she had a right rotator cuff repair in 12/11 and a left shoulder manipulation in 4/11, with subsequent referral to PT. Patient has been on medication. Her treating doctor has requested a repeat MR arthrogram, right shoulder, which has been denied.

The only note provided by the treating physician was regarding a follow up post-surgery visit on 12/27/11. At that time, the patient was doing well. The original injury had occurred on 8/30/10. Surgery was performed on 12/14/11 with extensive intra-articular and extra-articular debridement, rotor cuff repair and biceps tenotomy as some of the procedures performed. There are physical therapy notes present....most recently from 3/05/12. At that time, therapy described a flexion of 130, abduction of 90, extension - 48, internal rotation at 54 and external rotation of 65. Patient had some spasms and pain through range of motion. There is a note from the treating physician's office on 3/06/12 stating the patient would be capable of limited work. Physical therapy reports that patient was seen eleven times between 1/09/12 and 3/05/12. Unfortunately, there are not

follow up medical reports from the treating physician that would enable a reviewer to know the status of the patient's post-operative course.

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

I agree with the benefit company's decision to deny the requested services based on the inadequate documentation delivered to support further diagnostic studies. ODG does not recommend repeat MRI routinely over conventional arthrography without significant changes in symptoms and/or findings of significant pathology. There were no such reports provided.

**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
- X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- X 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**