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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 3/01/13

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

OP Left shoulder arthroscopy and MUA (manipulation under anesthesia) and lysis of adhesions CPT: 29822, 23700, 23455; request original receive date: 12/05/12

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

Physician Board Certified in Orthopedics

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overtuned (Disagree)

Partially Overtuned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

The data reviewed revealed the patient had a job related left shoulder dislocation occurring in. He also sustained an acetabular fracture. He underwent closed reduction of his shoulder dislocation in the emergency room and eventually underwent surgery for his acetabular. Patient was placed on extensive physical therapy but, unfortunately, apparently was not able to regain his motion. X-rays revealed Hill-Sachs lesion and a tear of the anterior/inferior labrum. Patient, by history, continued to have pain and limited motion.

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

Opinion: I disagree with the benefit company's decision to deny the requested services.

Rationale for opinion: Patient had sustained injury with a shoulder dislocation. He appears to have had good post operative rehabilitation in trying to help him regain normal function and, for whatever reason, this was not successful. In light of the fact that he continues to have significant limitation of motion and

pain, I think it is reasonable, at the very least, to do a manipulation under anesthesia. However, it would be better to do an arthroscopic examination at the same time to determine whether he has ongoing instability and requires additional treatment such as lysis of adhesions, and including possible aggressive therapy as indicated, to avoid recurrence of his limitation of motion.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH
ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE DESCRIPTION)