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IRO Certificate #4599

DATE OF REVIEW: 2/18/16

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Arthroscopic Shoulder w/RCR, Biceps Tenodesis, Distal Claviclectomy, including Distal Articular Surface;
CPT: 29827, 29828, 29824

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

Physician Board Certified in Orthopedic Surgery

REVIEW OUTCOME

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

Upheld	(Agree) <u>X</u>
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY

Patient is a male, left hand dominant, laborer, whose initial injury occurred in XX/XXXX, when a steel pipe fell on his left shoulder. He sustained a rotator cuff tear, confirmed by MRI (XX/XX/XX), treated with rotator cuff repair in XX/XXXX. Patient presented in XX/XXXX, with chief complaint of shoulder pain and weakness. Exam showed tenderness to palpation, left shoulder, AC joint tenderness, limited external rotation at 35 to 40 degrees, abduction of 60 degrees, abducted external rotation 70 degrees, pain with elevation, supraspinatus strength is graded 4-/5, subscap is 5-/5. XX notes say that MRI was reviewed showing a current tear of the supraspinatus. Of note is the MRI report is not available in the chart.

XX recommended surgical repair including bicep tenodesis and distal clavicular resection.

Patient was seen again and at that time his subacromial space was injected with Depo-Medrol, Marcaine, and lidocaine. A follow up again with XX, PA-C, 12/17/15, reports patient had significant relief after his injection but this was short-lived. Once again surgery was recommended.

Plain film x-ray of the left shoulder performed XX/XX/XX showed no acute abnormality, minimal AC joint subchondral sclerosis, and mildly elongated left C7 transverse process.

According to the two reviewers' notes, they recommended against surgical procedure based on absence of MRI Report review to determine deficit in the rotator cuff or impingement.

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

Opinion: I agree with the benefit company's decision to deny the requested service based on lack of documentation showing a deficit in the rotator cuff that would require surgical intervention.

Rationale: It is my opinion that the decision to proceed with revision rotator cuff surgery is based on clinical examination and history, as well as imaging studies. I feel that MRI is necessary to determine the exact nature of the pathology causing his recurrent symptoms.

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)