Envoy Medical Systems, LP **PH: (512) 705-4647**
1726 Cricket Hollow Drive **FAX: (512) 491-5145**
Austin, TX 78758 **IRO Certificate X**

Notice of Independent Review Decision

DATE OF REVIEW: X

IRO CASE NO. X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
X

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

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

Upheld (Agree)

Overturned (Disagree) X

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
X

PATIENT CLINICAL HISTORY SUMMARY
Request for X.

Denied. Lack of X as medically uneccesary.
Patient is a X claimant, DOI X. Mechanism of injury described as X.

Initial denial by Utilization Management, X, RN, X, recommended non-certification of the requested service due to X.

Second denial by X, MD, X, was deemed medically unnecessary due to X.

Appeal/Reconsideration Determination generated by X, LVN, Utilization Management,

X. X stated that the procedure was not medically necessary; the medical records do not demonstrate that patient has X.

Utilization Reviewer, X, Dr. X, recommended non-certification for the procedure due to X.

X discussion/summary, X, by Dr. X, stated patient X. Patient was treated with X.

Right shoulder x-rays, 3 views performed, X, report read by X, MD, stating X. Also noted that patient had X.

MRI of patient's right shoulder performed X and read by Dr. X. Findings
were of X. There was degenerative signal
in the X. Long head of the biceps had X. There is a small X. There is X. Rotator

cuff exam shows X. Complete tear of the supraspinatus and infraspinatus at the footprint with retraction to the subacromial space. There are X noted.

X discussion/summary dated X, patient started on X.

X discussion/summary dated X, note states X was switched to X and was discharged to X for X shoulder and was allowed to continue with work with
restrictions.

X Evaluation dated X, by Dr. X, MD, Orthopedic Surgeon, states X should be
evaluated for injuries sustained in the X work injury when X. X is right handed. Exam shows abrasions on the upper extremity, active forward flexion X, external rotation X, internal rotation to X belt, and abduction X degrees. Passively, abduction X degrees with pain, X has X. X has X. No
evidence of X. Diagnostic testing including the x-ray and MRI were reviewed. X impression was
of X. Recommended that X
try X. X was to continue with light duty.

X discussion/summary dated X, visit with X, MD, no change in status was
noted.

X Progress Report dated X, generated by Dr. X, MD, states patient has done
X. Pain
rated X. Impression was X,
. Recommendation was for X.

X Progress Report dated X, by Dr. X, MD, noted patient was X. Exam unchanged from X, tenderness, limited forward elevation of X degrees, and no instability. Dr. X recommended X.

PATIENT CLINICAL HISTORY SUMMARY (continuation)
X Progress Report dated X for X but note stated patient had reached X of X functional goal related to X shoulder.

X Note dated X, note stated X had completed X.

X Note dated X, noting X.

X Note dated X, once again noting X.

X Note dated X noting X.

X Note dated X noting X.

X Note X once again noting X

X Note X for X

Summary:
X fell down X. X specifically sustained a X. Physical exam consistent with significant X. Patient continues with pain. MRI confirms X. Patient has received X. X has not received any X. According to the notes, X does not appear to be improved.

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 service.
Rationale:
In my opinion, patient sustained work injury of X. I feel surgical repair of X is warranted to allow X to return to full duty work and I feel there is a X. In my opinion a X.

The denied service(s), X, is medically necessary for the

patient.

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

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

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

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

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