

Wren Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

Dec/08/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Shoulder Arthroscopy, Subacromial decompression, distal clavicle resection, rotator cuff, debridement and possible repair

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

M.D., board certified in Orthopedic Surgery

REVIEW OUTCOME:

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

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 10/13/09, 10/28/09

ODG Guidelines and Treatment Guidelines

Orthopaedic Surgery Group, 10/6/09

MD, 9/18/09, 5/4/09

Radiology Reports, 12/31/08

MD, 4/16/09, 3/16/09, 2/16/09, 1/19/09, 1/12/09, 1/5/09, 12/31/08, 9/11/09, 8/11/09, 7/9/09, 5/19/09

Radiology Report, 6/6/09, 1/6/09

MRI Right Shoulder, 8/18/09

PATIENT CLINICAL HISTORY SUMMARY

This case involves a woman who injured her right shoulder in a fall on xx/xx/xx. She has pain with overhead activity and pain at night. Records presented for the review show that she has had physical therapy, prednisone, ibuprofen, hydrocodone, nonsteroidal anti-inflammatory medication, and one injection into the shoulder. The most recent physical examination shows some acromial tenderness and pain with forward flexion. There is said to be some weakness of the rotator cuff and signs of impingement. The request for Shoulder Arthroscopy, Subacromial decompression, distal clavicle resection, rotator cuff, debridement and possible repair was denied by the insurance company and is the subject of this independent review.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

The previous reviewer denied this request on the basis that the records did not “provide clear documentation of the frequency or duration of physical therapy, and that “it is unclear what families of medications have been used. It is unclear whether or not there was a temporary response to subacromial injection. The MRI report is not available.”

Most of this information has now been provided in the records presented for this review, with the exception of the results of the subacromial injection of corticosteroid and Xylocaine. The MRI has been provided. Impression is Moderate to severe supraspinatus tendinopathy, mild infraspinatus tendinopathy, no full thickness rotator cuff tear identified, mild acromioclavicular joint osterarthritis with small amount of subacromial/dubdeltoid bursal fluid, which is most likely reactive. The patient has had nine months of failed conservative care according to the records. The physical therapy has been documented. The patient has had prednisone, ibuprofen, and nonsteroidal anti-inflammatory medication.

Based on the medical records provided, this reviewer finds that this request satisfies the criteria for the procedure as detailed in the Official Disability Guidelines and Treatment Guidelines. The reviewer finds that medical necessity exists for Shoulder Arthroscopy, Subacromial decompression, distal clavicle resection, rotator cuff, debridement and possible repair.

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

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

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)