

Wren Systems

An Independent Review Organization
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DATE OF REVIEW:

Mar/25/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopy, rotator cuff repair, debridement, decompression, distal claviclectomy, SLAP repair

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

MD, Board Certified Orthopedic Surgeon

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

PATIENT CLINICAL HISTORY SUMMARY

This injured female worker was injured on xx/xx/xx. The claimant has had extensive treatment with injections and physical therapy. She has had several MRI scans and has a diagnosis currently of a partial rotator cuff tear with significant tendinosis, stage II impingement, ongoing pain with range of motion and positive impingement test, and difficulty with elevation of the arm and nonamelioration currently of the currently symptoms. The request is for arthroscopy, rotator cuff repair, debridement, decompression, distal claviclectomy, and SLAP repair.

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

While the previous reviewer denied this case based on lack of compensability due to the time since injury, this reviewer's role is to determine medical necessity. Based on the ODG Guidelines for rotator cuff repair, cervical pathology has been ruled out as has frozen shoulder. She has pain with elevation. She has some weakness and MRI scans that have documented marked tendinosis as well as partial tear. She has had conservative care extensively and physical therapy, and she has the appropriate tenderness and positive impingement sign. It is for these reason that she meets ODG criteria, and it is for this reason that the medical necessity in this reviewer's opinion has been substantiated. As previously mentioned, no comment is made as to causation. The previous reviewer feels that impingement is a condition of ordinary disease of life and that was the reason for his denial as far as I can determine. However, as far as medical necessity is concerned, this reviewer believes that medical records support the medical necessity for the requested procedure. The reviewer finds that medical necessity exists for Arthroscopy, rotator cuff repair, debridement, decompression, distal claviclectomy, SLAP 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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