

Wren Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/09/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI of the Left Shoulder without Contrast

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

Official Disability Guidelines Treatment in Workers' Compensation, Shoulder, MRI
esis, 6/3/10, 7/12/10
7/15/10, 6/3/10, 6/15/10, 5/10/10, 4/13/10, 4/6/10
M.D. 6/3/10, 1/21/10
Orthopaedic Surgeons Associates 5/28/10, 5/26/10, 6/16/10, 6/18/10, 7/7/20, 7/22/10
1/27/10
East, 1/27/10

PATIENT CLINICAL HISTORY SUMMARY

This patient sustained a work-related injury where he felt popping in his shoulder and immediate weakness. He was seen and treated. On 5/4/09 he had an MRI scan, which revealed a large retracted rotator cuff tear. On 6/24/09 he had shoulder reconstructive surgery -- an open acromioplasty and open rotator cuff repair. He has consistent pain and loss of range of motion, apparently positive Neer and Hawkins sign. MRI scan from 1/27/10 revealed a ruptured biceps tendon. A previous reviewer has noted that given the time since injury, repair of the ruptured biceps tendon would not be appropriate.

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

The records indicate that this gentleman has consequences of open surgery and has loss of range of motion. The treating doctor has requested repeat MRI scan is to evaluate the extent and current position of the torn bicipital tendon. As the previous reviewer has noted, this information would not change the treatment protocol, and does not meet criteria/indications for imaging in the ODG Guidelines. This reviewer cannot find support in the ODG Guidelines or in the medical records from the requesting physician as to why the previous adverse determinations should be overturned. The reviewer finds that medical necessity does not exist for MRI of the Left Shoulder without Contrast.

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)