

# Wren Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Nov/06/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Right Shoulder Arthroscopy & Bicep Tenodesis (29805=Arthroscopy, shoulder, diagnostic, with or without synovial biopsy; 23430=Tenodesis of long tendon of biceps; 29828=Arthroscopy, shoulder, surgical; biceps tenodesis)

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., 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**

Official Disability Guidelines

10/4/10, 10/15/10

Orthopedics 12/18/03 - 10/14/10

Manual Progress Note 6/28/10

Pain and Injury Clinic 9/10/03 to 2/1/06

M.D. 10/30/04

M.D. 11/13/03 - 6/17/04

M.D. 7/16/03 - 9/5/03

Sports and Spine Rehabilitation 9/4/03

Diagnostic 7/1/10 - 9/20/10

Imaging Center 6/22/10 - 9/1/10

Medical Testing 7/14/03

Medical 11/2/04

Imaging and Diagnostic 6/21/04 - 10/18/04

Imaging, Inc. 12/1/03

Hospital 1/23/04

**PATIENT CLINICAL HISTORY SUMMARY**

This is an individual who has documented biceps pain on physical examination and has had good relief twice with injections over the bicipital groove. The claimant has had physical therapy, medications, and has full conservative care per ODG Guidelines. The MRI scan of the cervical spine was negative. The MRI scan of the right shoulder showed tendinitis of the distal supraspinatus, irregularity of the posterior glenoid, and the patient has failed conservative care. The patient has documented pain starting at 90 degrees with active arc range of motion.

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

Based upon the clinical history, response to treatment, and specificity of the injections, it is this reviewer's opinion that the ODG criteria are satisfied for the performance of this arthroscopy, as there is certainly some impingement on the MRI scan, the injections have given diagnostic clarity, and full conservative care has been exhausted. It is for these reasons that the adverse determination is overturned. The reviewer finds that medical necessity does exist for Right Shoulder Arthroscopy & Bicep Tenodesis (29805=Arthroscopy, shoulder, diagnostic, with or without synovial biopsy; 23430=Tenodesis of long tendon of biceps; 29828=Arthroscopy, shoulder, surgical; biceps tenodesis).

**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)