

# Wren Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Oct/01/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
ARTHROSCOPY W/REPAIR PERONEAL TENDON WITH FIBULAR OSTEOTOMY  
PLATELET GEL OF LEFT ANKLE

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

Doctor of Medicine (M.D.), Board Certified in Orthopaedic 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  
Inc. 8/23/10, 9/17/10  
M.D. 11/18/09 to 7/21/10  
Technologies 6/14/10  
Imaging Center 1/4/10, 10/26/09  
Hospital 12/7/09

**PATIENT CLINICAL HISTORY SUMMARY**

The patient suffered a lateral malleolus fracture that was complicated by chronic peroneal tendon problems after healing of the fracture. The patient failed conservative management for these peroneal tendon problems and surgery has been recommended to include arthroscopy with repair of the peroneal tendon and fibular osteotomy as well as use of platelet rich gel. The surgery has been denied by the insurance company as not medically necessary.

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

A review of the medical records shows that this patient is an appropriate candidate for ankle arthroscopy as well as peroneal tendon repair. Because of osteophytes over the lateral fibula, the osteotomy appears to be reasonable as well. The guidelines have been satisfied for these procedures. However, platelet rich plasma products are not indicated for this type of

procedure and have not been shown to be any better than placebo as per the evidence-based guidelines. The request as a whole is not medically necessary because of this portion of the request. The reviewer finds that medical necessity does not exist for ARTHROSCOPY W/REPAIR PERONEAL TENDON WITH FIBULAR OSTEOTOMY PLATELET GEL OF LEFT ANKLE.

**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

AHCPH-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)