

Wren Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/23/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left shoulder Arthroscopy, rotator cuff repair, Repair superior glenoid labrum tear

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

M.D., Board Certified 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
Pre-authorization review 01/26/12 regarding non-certification left shoulder arthroscopy, rotator cuff repair, superior glenoid labrum repair
Pre-authorization review regarding non-certification reconsideration request left shoulder arthroscopy, rotator cuff repair, superior glenoid labrum repair
Request for pre-authorization 01/23/12
MRI left upper extremity 08/25/09
MRI cervical spine 08/25/09
Radiology review x-ray cervical spine 01/15/10
Office notes 11/03/11-02/16/12
Request for reconsideration 02/14/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female whose date of injury is xx/xx/xx. She has left shoulder pain and neck pain. MRI of the left shoulder on 08/25/09 revealed a type 2 acromion with prominent AC hypertrophy. There is mild tendinosis of the rotator cuff with slight intrasubstance tearing but no sign of full thickness tear. There is question of a small tear of the anterior labrum. MRI of the shoulder is otherwise unremarkable. Left shoulder Arthroscopy, rotator cuff repair, Repair superior glenoid labrum tear is recommended by the provider.

The request was denied on 01/26/12. Official Disability Guidelines criteria were not met as the available documentation failed to indicate three months continuous or six months intermittent rehabilitation towards regaining shoulder range of motion and strength. There was no full thickness tear noted and conservative care has been shown to help in those instances.

The request was denied again on 02/24/12. The claimant does not have a SLAP tear on MRI. There was high risk for post-operative complications with SLAP repair. If there is significant SLAP tear or biceps pathology, then biceps tenodesis or tenotomy would be associated with

improved function without the risk of complication inherent to SLAP repair. There was no history of instability. There was no full thickness tear of the rotator cuff, and possible small anterior labral tear. There is a single note from 12/01/11. Two other visits with were documented but not available. It was noted that the claimant had an injection on 12/01/11, the same day that surgery was requested.

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

The claimant was injured on xx/xx/xx. MRI of the left shoulder was performed on 08/25/09, and showed type 2 acromion with prominent AC hypertrophy; mild tendinosis of the rotator cuff with slight intrasubstance tearing but no sign of full thickness tear; question of a small tear of the anterior labrum; otherwise unremarkable MRI. No more recent diagnostic/imaging studies were submitted for review. There is no comprehensive history of recent conservative care for the left shoulder. Records indicate that the claimant underwent injection of the left shoulder on 12/01/11. However, there is no indication that the claimant has had at least three to six months of conservative care including physical therapy with stretching and strengthening exercises. As noted on previous reviews, there is no evidence of SLAP lesion on MRI. As such the reviewer finds that Left shoulder Arthroscopy, rotator cuff repair, Repair superior glenoid labrum tear is not medically necessary at this time.

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)