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AMENDED Notice of Independent Review Decision

**DATE OF REVIEW: 5/29/07****IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Repeat MRI.

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

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal.

**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)

<i>Primary Dx Code</i>	<i>HCPCS</i>	<i>Mod</i>	<i>Units</i>	<i>Type Review</i>	<i>DOS</i>	<i>Amt Billed</i>	<i>Date of Injury</i>	<i>Claim #</i>	<i>Uphold / Overturned</i>
840.9	73221		1	Prospective					Uphold

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for Independent Review by an Independent Review Organization forms – 5/14/07
2. Determination Notices – 4/20/07, 4/25/07
3. Records and Correspondence from Institute of Texas – 3/7/07-4/23/07
4. Records and Correspondence from Imaging Center – 7/19/01

**PATIENT CLINICAL HISTORY:**

This case concerns an adult male who sustained a work related injury on x/xx/xx. Records provide no details about the circumstances of the injury. Diagnoses have included a spur, impingement syndrome and adhesive capsulitis. Evaluation and treatment for this injury has included surgery (2001), x-rays, an MRI, and rehabilitation services.

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

The patient was injured on x/xx/xx. The patient underwent initial treatments including passive modalities and active exercise to the left shoulder. Eventually he had surgery to the left shoulder which included a distal clavicle resection. The records reported that there were x-rays taken of the left shoulder which revealed a small spur inferior to the distal left clavicle. According to the Official Disability Guidelines (2006) regarding acute and chronic shoulder injuries, MRIs should be employed if a surgical approach is being considered, if the diagnosis is unclear, or if the clinical examination was limited. According to the medical records, no surgery was being considered at the time, the patient was diagnosed with a bone spur, and he had a thorough examination which included x-rays of the area. Thus, with the patient not meeting the Official Disability Guidelines criteria regarding imaging of the shoulder, the requested repeat MRI of the left shoulder 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- AMERICAN 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)**