

**Notice of Independent Review Decision  
AMENDED TO ADD MR. xxxx TO INTERESTED PARTIES**

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 03/30/08

**IRO CASE #:**

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

Right shoulder MR arthrogram post MRI scan

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., board certified orthopedic surgeon.

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
71941	73040		Prosp.						Upheld
71941	22350		Prosp.						Upheld
71941	Q9962		Prosp.						Upheld
71941	A4550		Prosp.						Upheld
71941	99070		Prosp.						Upheld
71941	77003		Prosp.						Upheld
71941	73221		Prosp.						Upheld

**INFORMATION PROVIDED FOR REVIEW:**

1. TDI case assignment.
2. Letters of denial 02/15 & 03/03/08, and criteria for denial (ODG) and URA documentation.
3. Orthopedic evaluations, progress notes & radiology reports February & March 2008.

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The patient sustained an injury to the shoulder and was evaluated and clinical exam was done. MRI scan was done showing tendinosis along with some subdeltoid bursitis and changes at the acromioclavicular joint. Diagnosis of impingement syndrome with bursitis was made. The treating physician then further requested an MRI scan arthrogram.

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

It would appear to me that the data available, that is, the history, clinical examination, and the MRI scan, are adequate to perform a diagnostic evaluation of the patient. Right shoulder MR arthrogram post MRI scan is not medically necessary in this case.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:**

*(Check any of the following that were used in the course of your review.)*

- ACOEM-American 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)