

RYCO MedReview

Notice of Independent Review Decision

DATE OF REVIEW: 03/31/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat MRI of the right shoulder

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

Board Certified in 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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Repeat MRI of the right shoulder - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A Workers' Compensation Insurance Verification Form dated 08/24/06
Evaluations with M.D. dated 08/29/06, 09/19/06, 06/11/07, 08/10/07, 10/15/07,
10/24/07, 11/12/07, 11/26/07, 01/03/08, 01/09/08, 01/31/08, and 02/20/08

An MRI of the right shoulder interpreted by D.A.B.R. dated 09/06/06
Physical therapy evaluations with an unknown therapist (signature was illegible) dated 01/02/07, 11/14/07, 12/14/07, 01/02/08, and 01/30/08
An arthrogram of the right shoulder interpreted by M.D. dated 10/02/07
An MRI of the right shoulder interpreted by M.D. dated 10/10/07
An operative report from Dr. dated 11/12/07
Physical therapy with M.S., P.T. and P.T. dated 11/16/07, 11/19/07, 11/21/07, 12/07/07, 12/10/07, 12/12/07, 12/17/07, 12/19/07, 12/21/07, 12/26/07, 12/28/07, 12/29/07, 12/31/07, 01/14/08, 01/16/08, 01/19/08, 01/21/08, 01/23/08, and 01/25/08
A DWC-73 form from Dr. dated 01/20/08
A letter from M.D. dated 01/31/08
Letters of denial dated 02/18/08 and 02/27/08
A PLN-11 form of dispute from the insurance carrier dated 03/06/08
An undated letter of denial from an unknown person (no name or signature was available), according to the ODG
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

On 08/29/06, Dr. recommended an MRI of the right shoulder, Vicodin, and Skelaxin. An MRI of the right shoulder interpreted by Dr. on 09/06/06 revealed a small full thickness tear of the supraspinatus critical zone and AC joint arthrosis hypertrophy. On 09/19/06, Dr. recommended right shoulder surgery. An MRI arthrogram of the right shoulder interpreted by Dr. on 10/02/07 revealed possible type I or II shoulder separation and a full thickness rotator cuff tear. An MRI of the right shoulder interpreted by Dr. on 10/10/07 revealed a recurrent rotator cuff tear. On 10/15/07, Dr. recommended another right shoulder surgery. On 10/24/07, Dr. performed a steroid injection to the right shoulder. Right shoulder surgery was performed by Dr. on 11/12/07. Physical therapy was performed with Mr. and Mr. from 11/16/07 through 01/25/08 for a total of 19 sessions. On 01/31/08, Dr. recommended a repeat MRI of the right shoulder. On 02/18/08 and 02/27/08, wrote letters of denial for a repeat MRI of the shoulder. On 03/06/08, a PLN-11 form filed by the insurance carrier indicated they disputed right hip arthritis and pain, right testicle pain, right shoulder pain, and the inability to move the right shoulder.

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

This patient has not met the requirement for a repeat MRI of the right shoulder. There has not been ample evidence of a change in the status of the patient's right shoulder. In fact, there has been plenty of evidence in the recent notes as late as February, which state the patient's pain was rated at about 5-6/10 and has been as such during most of the postoperative period. There was no

evidence of a new injury or new exacerbation. Thus, I would state that there is no reason for a repeat MRI. A surgical outcome with pain, not as relieved as one would expect, is not an indication for a repeat MRI after surgery. Therefore, the repeat MRI of the right shoulder is not reasonable or necessary.

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)