

US Resolutions Inc.

An Independent Review Organization

71 Court Street

Belfast, Maine 04915

Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 19, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

73221, MRI Left Shoulder and Chest Post Op

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

MD, Board Certified Orthopedic Surgeon

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.

The reviewer finds that medical necessity does not exist for 73221, MRI Left Shoulder and Chest Post Op.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/22/08, 9/19/08

ODG Guidelines and Treatment Guidelines

, MD, 7/24/08

3/14/08

, 4/21/08, 2/25/08

Patient Info, 2/12/08

Dr. , MD, 8/11/08

MRI, 4/30/08, 2/12/08

, MD, 4/24/08, 4/15/08, 5/2/08

, DC, 9/15/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is an injured worker who apparently was using a buffer when the machine jerked and pulled his left shoulder forward. He underwent an MRI scan in February 2008 and was found to have a full thickness supraspinatus tear with associated acromioclavicular arthropathy. On 03/31/08 he underwent arthroscopic surgery with mini-open repair and a rotator cuff repair. He had postoperative pain and infection and underwent a repeat MRI scan on 04/30/08, which showed an intact rotator cuff. There is a request now for a third MRI scan of the shoulder, i.e., a second postoperative MRI scan and a chest scan.

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

This reviewer could not find in the medical record, nor could the previous reviewer, the medical necessity for the request made by the chiropractor for these studies. The postoperative MRI scan documents that an adequate surgical repair has been accomplished. Based upon this postoperative MRI scan and lack of medical necessity within the medical records, the reviewer finds that medical necessity does not exist for 73221, MRI Left Shoulder and Chest Post Op.

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)**