

Notice of Independent Review Decision

DATE OF REVIEW: 10/15/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI left shoulder

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from University of Maryland School of Medicine and completed training in Orthopaedics at University Hospital at Case Western Reserve. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Orthopaedics since 2004.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

| | |
|---|----------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in |

part) Repeat MRI left shoulder Upheld

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The xx year old female had subacromial decompression and distal clavicle excision on 7/12/2005. Recent x-rays reported osteophyte formation on the distal clavicle. The provider requests an MRI to evaluate if the distal clavicle tip is creating her discomfort and to be sure there is no injury to the rotator cuff due to the spur.

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

The injured worker had previous shoulder surgery in July 2005 and has adhesive capsulitis. Notes indicate ROM is flexion to 120, ER to 20, positive impingement (despite subacromial decompression and distal clavicle resection) and positive Hawkins sign. Radiographs with distal clavicle spur. Considering that the injured worker had distal clavicle resection in past, the likelihood of a spur causing the pain is very low. In addition, she has diagnosis of adhesive capsulitis and clinical notes supporting decreased ER; that is more likely contributing to pain. No mention is made of Drop arm test-to evaluate integrity of cuff clinically.

According to ODG guidelines, the request is denied. The additional information would not change the treatment plan. In addition, review of literature did not provide cases/discussion of rotator cuff tear after SA decompression and distal clavicle resection or spurring after a distal clavicle resection causing a RC tear.

Additional medical records were received for review, including physician's last notes from 8/2008 and operative report and subsequent post op notes, mainly from 2006.

The decision does not change with this information. The injured worker has a diagnosis of athrofibrosis and the physician wants an MRI to see if osteophyte is a source of pain. The clinical exam notes are negative for rotator cuff tear. Clinical exam notes are positive for impingement - which is a reason the injured worker had surgery in first place (subacromial decompression and distal clavicle resection for impingement). She has a recurrence of same problem, plus adhesive capsulitis. MRI will not change treatment plan as the information garnered from whether or not osteophyte is bothering patient.

The request is considered not medically necessary in accordance with the ODG guidelines and therefore the previous denial is upheld.

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

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
X 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)