

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

Nov/29/2009

### IRO CASE #:

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

MR Arthrogram of the right shoulder

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

M.D., 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)

### INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 10/30/09, 11/6/09

MD, 9/17/09, 10/14/09, 9/23/09

MR - Shoulder Right w/o Contrast, 1/28/09

MRI Left Foot, 10/7/09

MRI Left Ankle, 10/7/09

Peer Review Report, 10/28/09, 11/4/09

Preauth Form, Dr. 11/9/09, 10/7/09

Dr. ,DC, 7/29/09

EMG/NCV, 8/3/09

Peer Review, 9/3/09, 9/29/09

ODG Guidelines

### PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who was initially injured after a fall on xx/xx/xx and had a rotator cuff repair. The patient subsequently underwent a rotator cuff repair, subacromial decompression and distal clavicle resection in October 2008. An MRI scan was performed in January 2009 after the surgery and prior to this request, which showed a rotator cuff repair. The clinical examination showed the patient has loss of range of motion, weakness of the rotator cuff stated to be a global weakness, as well as history of pain at night. Current request is for an MR arthrogram of the shoulder.

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

The request to perform this shoulder MR arthrogram is not medically necessary. The reason given by the provider for the arthrogram is to re-evaluate the rotator cuff for its integrity. However, it is already known from the postsurgical MRI scan from January 2009 that there is a residual rotator cuff repair. Hence, the diagnosis has already been made on a noncontrast MRI scan, and based upon this reviewer's medical judgment and clinical experience, no additional valuable information would be gleaned from an arthrogram MRI scan of the shoulder. Furthermore, the request does not meet the ODG guidelines. This patient is either a surgical candidate or not based upon the physician's evaluation that the residual rotator cuff has already been diagnosed in January 2009. For this reason, the previous adverse determinations cannot be overturned. The reviewer finds that medical necessity does not exist for MR Arthrogram of the right shoulder

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

ACOEM-AMERICA 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)