

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/29/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI Right Shoulder and Repeat MRI Left Shoulder

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Range of motion testing, 09/15/09

Letter of medical necessity, Dr., 09/30/09

Adverse Determination Letters, 10/28/09, 10/7/09

PATIENT CLINICAL HISTORY SUMMARY

This is a female claimant with bilateral shoulder, upper extremity and wrist pain due to repetitive movements of the bilateral upper extremities reported in xx/xx/xx. The records indicated that since that time, the claimant has been treated with a conservative treatment regime and not improved. Continued pain, weakness and swelling were reported. Bilateral shoulder MRI's were performed on 09/22/05. The right shoulder showed mild subacromial impingement with degenerative changes of the acromioclavicular joint with subacromial bursal inflammation. The left shoulder MRI showed mild subacromial impingement with acromioclavicular joint degenerative arthropathy and cuff tendinopathy along with a small joint effusion. According to the treating physician, bilateral shoulder MRI's were recommended due to persistent symptomatology.

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

The reviewer is unable to recommend the bilateral shoulder MRI requested in this case as medically necessary. This person is now more than three years out from a maximum medical

improvement determination. There is no evidence of recent injury or recent change in condition. It is unclear from the records provided if any recent conservative care has been provided. For these reasons I would not be able to recommend as medically necessary the proposed magnetic resonance studies of both shoulders. The request does not conform to the Official Disability Guidelines Treatment in Worker's Comp 2009 Updates, Shoulder: Magnetic resonance imaging (MRI). The reviewer finds that medical necessity does not exist for Repeat MRI Right Shoulder and Repeat MRI Left Shoulder.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates, Shoulder: Magnetic resonance imaging (MRI)

Indications for imaging -- Magnetic resonance imaging (MRI)

- Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiograph

- Subacute shoulder pain, suspect instability/labral tear

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)