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Notice of Independent Review Decision

DATE OF REVIEW: 10/4/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of an MRI arthrogram of the right shoulder.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. This reviewer has been practicing for greater than 10 years in this specialty and performs this type of procedure in his office.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of an MRI arthrogram of the right shoulder.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:

, MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from : RN letter – 9/15/09; denial letter – 8/13/09 & 8/24/09; review report – 8/13/09 & 8/24/09; , MD Pre-authorization request –

8/11/09, Pre-authorization appeal – 8/20/09; MRI right shoulder report – 7/22/09.
Records reviewed from , MD: Dr. Operative Report – 1/29/08 & 8/5/08, Office Notes – 7/14/08-9/9/09; MRI/Arthrogram report – 6/23/08 & 1/6/09.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male. He was injured on xx/xx/xx while pulling a stuck piece off a molding machine. The patient underwent an MR arthrogram revealing a torn labrum. On 8/5/08, he underwent arthroscopy, excision loose bodies, SLAP repair, and chondroplasty of the right shoulder. Persistent pain and limited AROM prompted a restudy with MRA which revealed a small articular tear of 16.5mm proximal to its insertion and a persistent tear of the labrum in the previous tear's location. A repeat surgery was carried out on 1/29/09 (misdated on the report as 2008) with suture removal, debridement, and chondroplasty. Persistent pain and lack of full ROM prompted restudy and an MRI dated 7/22/09 shows post-op changes with no rotator cuff tear with possible labral fraying. The patient requests repeat MR arthrogram.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
The patient has already received a postoperative MRI. A previous arthroscopy has shown the SLAP tear to have healed and no subsequent treatment related injury has occurred; therefore, there is no medical necessity for this procedure.

According to the ODG: Magnetic resonance imaging (MRI) and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific.

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)**