

I-Decisions Inc.

An Independent Review Organization
5501 A Balcones Drive, #264
Austin, TX 78731
Phone: (512) 394-8504
Fax: (207) 470-1032
Email: manager@i-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/18/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MR Arthrogram Right Shoulder

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

Doctor of Medicine (M.D.), Board Certified in Orthopaedic 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

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 7/2/10, 7/12/10
M.D. 12/18/09 to 6/29/10
, no date
Medical Center 1/4/10, 12/15/09

PATIENT CLINICAL HISTORY SUMMARY

This female patient has undergone a previous open acromioplasty and rotator cuff repair. She has lost active abduction after initial gains. She continues to have pain and weakness. An MR arthrogram was requested and has been denied by the insurance company. The first reviewer denied the MRI arthrogram because the surgeon did not document objective data. The second reviewer, who is an orthopedic surgeon, denied the MRI arthrogram because the patient does not have any labral tear or instability.

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

The MR arthrogram is medically necessary to see if the rotator cuff repair has failed. The clinical documentation and rationale for the request has been outlined sufficiently by the treating provider. The request meets all of the ODG requirements and guidelines. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned. The reviewer finds that there is medical necessity for MR Arthrogram 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)**