



Amended February 8, 2010

REVIEWER'S REPORT

DATE OF REVIEW: 02/01/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Right shoulder MRI scan arthrogram

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering shoulder injuries

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. ZRC forms
2. TDI referral forms
3. Denial letters, 12/28/09 and 01/13/10
4. Initial evaluation, 08/19/09
5. Bone scan, 01/12/10
6. M.D., evaluation 12/15/09
7. TWCC-73, eleven entries between 01/15/08 and 12/16/09
8. Operative report, M.D., 04/24/08
9. Chest x-ray, 04/24/08
10. Scapula x-rays, 08/25/08 and 07/12/08
11. MRI scan of right shoulder, 02/29/08
12. clinical notes, fourteen entries between 01/15/08 and 12/08/08

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is a female who suffered a direct blow injury to her right shoulder when a heavy object fell from a height above her, striking her right shoulder and knocking her to the ground. She was evaluated for right shoulder pain. Eventually on 04/24/08, an arthroscopic surgical procedure was performed for subacromial decompression and rotator cuff repair of the right shoulder. The patient has had persistent symptoms and most recently has been recommended for a repeat special study MRI arthrogram based on an evaluation 12/15/09. The evaluation by MRI arthrogram has been considered, denied, reconsidered and denied.

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

Unfortunately, the single medical record which specifically refers to a request for the performance of an MRI arthrogram is only partially legible. Current symptoms and range of motion are not present in the clinical note. As such, the indications for an MRI arthrogram are not clear. The prior denials were appropriate and should be upheld.

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

(Check any of the following that were used in the course of your review.)

- 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)