



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 06/22/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat Right Shoulder MRI/Arthrogram

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

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Repeat Right Shoulder MRI/Arthrogram - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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PATIENT CLINICAL HISTORY (SUMMARY):

The patient underwent a right shoulder arthrogram which showed degenerative signal at the supraspinatus tendon without a definite surface reaching tear. There were degenerative changes in the subcortical region at the greater tuberosity of the humeral head. X-rays of the right shoulder showed mild degenerative changes. The patient had undergone a course of corticosteroids, as well as a short course of physical therapy. The patient apparently exacerbated the previous shoulder injury and underwent an additional course of physical therapy. A repeat MRI was requested due to the his continued symptomatology.

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

A repeat right shoulder MRI/Arthrogram would not be reasonable or necessary. The patient does not have a documented significant re-injury or documented change in

physical examination findings that would support repeat imaging in line with nationally accepted criteria of Minnesota Rule 5221.6100, which indicates under Parameters for Medical Imaging; repeat imaging is indicated to diagnose suspected fracture, suspected dislocation, to monitor treatment or therapy which is known to result in change in imaging findings, to follow up a surgical procedure, to evaluate a new episode of injury or exacerbation which in and of itself would warrant an imaging study, or when the treating healthcare provider or a radiologist from a different practice have reviewed a previous imaging study and agree that it is technically inadequate. At this time, the medical records do not document any such criteria.

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)