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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/23/2010

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: 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

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter shoulder, MR arthrogram

Office notes 10/01/08, 06/08/09, 04/15/10

Treatment notes, right shoulder 10/08/08, 10/15/08

MRI right shoulder 10/17/08

Office notes Dr 11/04/08, 12/18/08, 02/04/09, 06/23/09, 07/15/09, 08/27/09

Office note Dr. 09/11/09, 10/16/09, 03/29/10, 04/30/10

EMG 10/08/09

Letter Dr. 10/18/09

Form Dr. 01/22/10

Office note Dr. 01/18/10

Peer review Dr. 04/08/10

Letter Dr. 04/30/10

Peer review Dr. 05/03/10

4/8/10, 5/3/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male diabetic who was status post a right shoulder arthroscopy, decompression inferior labral tear, arthroscopic debridement SLAP lesion, arthroscopic SLAP repair, arthroscopic debridement partial rotator cuff tear, arthroscopic subacromial decompression with acromioplasty, arthroscopic rotator cuff repair. Postoperatively, the claimant developed arthrofibrosis of the right shoulder and underwent a 07/15/09 right shoulder manipulation under anesthesia. Dr. has followed the claimant through April 2010. Examination revealed right side elevation to 110 degrees actively, passive to 165 degrees, external rotation to 50

degrees actively and 60 degrees passively. Supraspinatus strength was 4/5 and infraspinatus strength was 4/5. Dr. stated that the claimant had impingement, CBA positive, weakness and positive speeds. Dr. stated that right shoulder subacromial and acromioclavicular injections were given and post exam noted 50 percent improvement.

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

The requested right shoulder MR arthrogram is medically necessary based on review of this medical record. This is a male who injured his right shoulder in xx/xx. He had diagnostic testing and conservative care and on 02/04/09 underwent a right shoulder arthroscopic procedure for labral repair, partial rotator cuff debridement, acromial decompression and arthroscopic rotator cuff repair. Post operatively he was treated with physical therapy, activity modification and had ongoing stiffness and was returned to surgery on 07/15/09 for a manipulation under anesthesia. He had injections and has continued to have ongoing pain and limitation in function. The medical records of Dr. document ongoing lack of improvement with ongoing pain and limitation in function. ODG Guidelines document the use of MR arthrogram to detect labral tears. This is somewhat of a different case in that this claimant has already had surgical intervention and an MRI following surgery is more difficult to interpret than an MR arthrogram. The claimant has clearly had appropriate amounts of conservative care following surgery with ongoing pain and limitation in function. It is medically necessary to allow the physician to do a diagnostic test to make an anatomic diagnosis and determine whether or not further treatment and/or surgery is necessary. Therefore in light of this claimant's ongoing pain and limitations in function and the fact he has not improved with appropriate surgery and post operative care, then the requested MR arthrogram is medically necessary in an attempt to determine if further care is needed. The reviewer finds that medical necessity exists for MR Arthrogram Right Shoulder.

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Recommended as an option to detect labral tears. MRI is not as good for labral tears, and it may be necessary in individuals with persistent symptoms and findings of a labral tear that a MR arthrogram be performed even with negative MRI of the shoulder, since even with a normal MRI, a labral tear may be present in a small percentage of patients. Direct MR arthrography can improve detection of labral pathology.

Indications for imaging -- Magnetic resonance imaging (MRI)

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

- 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)