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### Notice of Independent Review Decision

**DATE OF REVIEW:** 5/27/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of CPT 23350 (injection procedure, shoulder arthrography) and 73040 (shoulder arthrogram).

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

The reviewer is a Doctor of Chiropractic with greater than 15 years of practice.

**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 CPT 23350 (injection procedure, shoulder arthrography) and 73040 (shoulder arthrogram).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
DC

These records consist of the following (duplicate records are only listed from one source):  
Records reviewed from Dr.: 5/12/10 letter by Dr., 4/8/09 impairment rating report, 4/28/10 addendum by Dr, 1/4/10 to 4/1/10 reports by Dr. 6/22/09 right shoulder MR arthrogram and

xray arthrogram reports, 8/17/09 operative report, 3/24/10 69 report, 4/9/10 re-eval report, 5/4/10 preauth request, 5/5/10 denial letter and 4/26/10 denial letter.

IMO: 4/14/10 denial letter, 4/22/10 letter by DC, 4/13/10 report by DC, 4/19/10 arthrogram script, 1/13/10 report by Dr. and 1/4/10 diagnostic interpretation report.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker was injured on xx/xx/xx. She fell while walking into the elevator landing on the right side of her body. She was initially treated by. She was referred to an orthopedic specialist, who performed a right subacromial decompression, distal clavicular excision, labral and glenohumeral debridement as well as an MUA on 8/19/09. She changed treating doctors approximately a month later.

She was pronounced to be at MMI on 1/14/10. She is at full duty without restriction at this point. The latest examination reveals painful ROM and orthopedic testing during almost all of the provocative testing including the shoulder, knee and cervical spine.

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

According to the ODG, an arthrogram is recommended as indicated below. Magnetic resonance imaging (MRI) and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific. Magnetic resonance imaging may be the preferred investigation because of its better demonstration of soft tissue anatomy. Subtle tears that are full thickness are best imaged by arthrography, whereas larger tears and partial-thickness tears are best defined by MRI. Conventional arthrography can diagnose most rotator cuff tears accurately; however, in many institutions MR arthrography is usually necessary to diagnose labral tears.

Dr. notes indicate the patient is having trouble while performing approximately 10 minutes of typing. They also indicate she has trouble during ROM and ortho testing. The 4/9/10 note states the patient indicates that "her pain levels have increased, since she has stopped her physical rehabilitation" and she has terminated her home exercise protocols secondary to fear of reinjury. This seems to be a contradiction to the reviewer.

There has been no documented reinjury for this patient whose job is data entry. Therefore, the documentation does not support the medical necessity for another arthrogram at this time.

**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)