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**Notice of Independent Review Decision
IRO REVIEWER REPORT – WC (Non-Network)**

DATE OF REVIEW: 03/08/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat MR arthrogram of the left shoulder

**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 MR arthrogram of the left shoulder - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 04/10/09, 04/24/09, 06/02/09, 06/10/09, 07/01/09, 08/04/09, 09/15/09, and 01/15/10

An MR arthrogram of the left shoulder interpreted by an unknown provider (no name or signature was available) dated 04/20/09

Surgery with Dr. dated 06/01/09

An MRI of the left shoulder interpreted by an unknown provider (no name or signature was available) dated 09/29/09

A letter of non-certification, according to the Official Disability Guidelines (ODG), from, M.D. dated 01/22/10

An evaluation with, M.D. dated 01/28/10

A letter of non-certification, according to the ODG, from, M.D. dated 02/02/10

A Physical Performance Evaluation (PPE)/Functional Capacity Evaluation (FCE) with, O.T. dated 02/08/10

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

An MR arthrogram of the left shoulder on xx/xx/xx showed a multi-quadrant labral tear with a 1 cm. posterior superior paralabral cyst and posterior subluxation of the humeral head. Left shoulder surgery was performed by Dr. on 06/01/09. On 08/04/09, Dr. recommended continued physical therapy. An MRI of the left shoulder on 09/29/09 showed only evidence of a prior labral repair with no recurrent tear. On 01/22/10, Dr. wrote a letter of non-certification for another left shoulder MR arthrogram. On 01/28/10, Dr. felt the patient was not at Maximum Medical Improvement (MMI) and recommended further physical therapy, a repeat MRI of the shoulder, and FCE. On 02/02/10, Dr. wrote a letter of non-certification for another MR arthrogram of the left shoulder. A PPE/FCE with Mr. on 02/08/10 indicated the patient should start DARS and would benefit from 10 sessions of work conditioning.

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

Based on the records provided, the patient is having some left shoulder instability and it appears he also has some global atrophy about the left shoulder. However, this instability has appeared late in the clinical picture. Furthermore, the patient underwent a previous repeat MR arthrogram with no abnormalities noted. Without objective evidence of impingement, evidence of a previous dislocation/subluxation event, and given the lack of objective findings of a Bankart lesion or a rotator cuff issue, a repeat MR arthrogram of the left shoulder would not be reasonable or necessary. Therefore, the previous adverse determinations, in my opinion, should be upheld.

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 AND KNOWLEDGE BASE
- 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)