

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 04/07/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat MRI left shoulder

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

The TMF physician reviewer is a licensed chiropractor with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the repeat MRI of the left shoulder is not medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 03/06/10
- Letter of determination from– 11/19/09, 02/18/10, 03/17/10
- Report of MRI of the left shoulder – 04/12/07
- Patient Re-evaluation by Dr.– 05/04/07 to 02/12/10
- IRO Summary from Claims Management – 03/30/10

- Notice of Independent Review Decision from– 10/12/07
- Employers first Report of Injury or Illness – 03/02/07
- Review determination from Direct – 04/03/07, 05/10/07, 09/24/07, 02/28/08, 04/02/08
- Letter of determination from – 09/10/08, 12/21/08
- History and Physical by Dr.– 02/26/07
- Initial Consultation by Dr.– 03/07/07
- Return to work activity prescription by Dr.– 03/08/07
- Prescription for EMS Unit by Dr.– 04/02/07 to 06/02/07
- Daily progress notes by Dr.– 04/01/07 to 11/30/09
- History and Physical by Dr.– 04/12/07
- Prescriptions for therapeutic products – 05/21/07 to 10/21/08
- Report of MRI of the Lumbar spine – no date
- Report of FCE Testing – 09/14/07, 12/05/07
- Impairment and Maximum Medical Improvement Determination by Dr.– 12/10/07
- Report of Range of Motion Testing – 06/18/08, 11/06/09

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when he was pushing 10 to 11 carts and felt a sharp snap in the middle portion and lower portion of his back which was followed by pain. At that time he had subjective symptoms of back pain, low back pain, stiffness in the neck and left shoulder pain. Objective findings were present and the treating doctor instituted a treatment plan. The MRI of the left shoulder performed on 04/12/07 revealed no specific significant injury as it relates to the on-the-job injury. Over the course of treatment the patient received chiropractic care, therapy, medication and appropriate diagnostic testing.

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

This patient had originally injured his left shoulder in the on-the-job injury dated xx/xx/xx. The original MRI performed on 04/07/07 was essentially normal. The treatment he received had essentially resolved any type of left shoulder problems. This is documented with the fact that for several re-examinations over one to two years, no specific problem with the left shoulder was found. Given this information, the ODGs do not allow for a repeat left shoulder MRI. It would not be medically necessary for this patient to receive a current left shoulder MRI as a result of his original on-the-job injury.

#### **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)