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

DATE OF REVIEW: 09/24/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder MR 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.

Right shoulder MR arthrogram - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Right shoulder arthrograms interpreted by M.D. dated 09/29/08, 10/10/08, and 06/25/09

MRIs of the right shoulder interpreted by, M.D. dated 10/10/08 and 06/25/09

X-rays of the right shoulder interpreted by, M.D. dated 10/10/08

X-rays of the chest interpreted by, M.D. dated 10/28/08

Operative reports from, M.D. dated 10/28/08 and 09/01/09

A Designated Doctor Evaluation with, M.D. dated 08/24/09

An MRI of the right shoulder interpreted by, M.D. dated 05/25/10

Evaluations with, D.C. dated 06/25/10, 07/12/10, and 07/14/10

A peer review report from, D.O. dated 07/15/10

A letter of non-certification for a right shoulder arthrogram, according to the Official Disability Guidelines (ODG), from Dr. dated 07/19/10

A peer review report from, D.C. dated 07/26/10

A letter of non-certification for a right shoulder arthrogram, according to the ODG, from Dr. dated 07/27/10

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

PATIENT CLINICAL HISTORY

Right shoulder arthrograms were interpreted by Dr. on 09/29/08 and 10/10/08. An MRI of the right shoulder interpreted by Dr. on 10/10/08 showed prominent fibrocystic changes of the posterior

superior humeral head with findings suggestive of internal impingement, mild irregularity of the anterior/superior labrum with a possible tear, and signal changes of the distal supraspinatus suggestive of a partial thickness tear or tendinopathy. X-rays of the right shoulder interpreted by Dr. on 10/10/08 showed a possible small partial tear in the supraspinatus tendon. On 10/28/08, Dr. performed a right shoulder arthroscopy with type II SLAP repair, subacromial decompression, and synovectomy. A right shoulder MRI interpreted by Dr. on 06/25/09 showed postoperative changes in the glenoid and continued fibrocystic changes of the posterior superior humeral head probably due to internal impingement. On 08/24/09, Dr. felt the patient was not at Maximum Medical Improvement (MMI) and noted another surgery had been scheduled. On 09/01/09, Dr. performed a right shoulder arthroscopy with limited debridement, biceps tenotomy, and open subpectoral biceps tenodesis. An MRI of the right shoulder interpreted by Dr. on 05/25/10 showed postsurgical changes, mild rotator cuff tendinopathy, and mild AC joint osteoarthritis. On 07/19/10, Dr. wrote a letter of non-authorization for a right shoulder arthrogram. On 07/27/10, Dr. also wrote a letter of non-authorization for a right shoulder arthrogram.

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

This patient has had two appropriate surgeries and has failed to get lasting relief or improvement from either. In my opinion, a certain amount of this patient's pain will most likely be chronic in nature and it may be difficult to rid him of all of his pain. With regard to the current request for an MR arthrogram, this patient underwent a non-arthrogram MRI scan on 05/25/10, but there was really no evidence of rotator cuff pathology. In fact, the quote is "mild rotator cuff tendinopathy without evidence of a tear." With these findings noted on the MRI, an MR arthrogram would add little to the power of the diagnosis of the MRI scan. Furthermore, the ODG recommends MR arthrogram a diagnostic option to detect labral tears, which does not appear to be the case with this patient. Therefore, the requested right shoulder MR arthrogram is neither reasonable nor necessary and the previous adverse determinations 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
- X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- X 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)