AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 29, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

MRI of the Left Shoulder Without Contrast between 9/1/2010 and 10/31/2010.

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

This physician is a Board Certified Orthopedic Surgeon with 42 years of experience.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On September 15, 2009, the claimant was evaluated by, M.D. Dr. review of the claimants MRI revealed at C3-4, C4-5, C5-6 and C6-7 contained disk herniation

rated as stage 2 with annual herniation nuclear protrusion and spinal stenosis. This is worse at C5-6 and C6-7.

On October 13, 2009, the claimant was evaluated by M.D. Impression: Cervical herniation nucleus pulposus C3-4, C4-5, C5-6 and C6-7, with collapse C5-6 and C6-7. Dr. recommended decompression diskectomy at C3-4 and C4-5 along with decompression diskectomy and arthrodesis at C5-6 and C6-7.

On November 9, 2009, an EMG of the upper extremities was performed. Impression: There is evidence of acute left C6-7 cervical radiculopathy. There is evidence of moderate bilateral median mononeuropathy at the level of the wrist as interpreted by, M.D.

On March 1, 2010, the claimant underwent a psychological evaluation with M.S., L.P.C. The claimant was given a good prognosis for surgical procedure.

On August 10, 2010, the claimant was re-evaluated by M.D., P.A. The claimant is 60 days post open from a cervical fusion. He is doing well but is having shoulder pain. Impression: 1. Impingement syndrome, rule out rotator cuff tear. 2. Status post cervical spine reconstruction. Dr. recommended an MRI of the left shoulder.

Date Unknown: , M.D. was asked to address the following question: 1. Please address medical necessity of ongoing medical treatment. Answer: This claimant did not sustain a dislocation of the left elbow, but rather a partial tear of the common flexor muscle mass attached to the lateral epicondylar region of the left elbow.

On September 7, 2010, D.O., an occupation medicine specialist performed a utilization review on the claimant. Rationale for denial: There was a previous left shoulder MRI performed on 1/21/09 witch showed tiny focal undersurface tear at the junction of the supra and infraspinatus tendons. The official report of the previous left shoulder MRI was not provided. There is no relevant documentation that validates the patient had completed a significant course of conservative treatment. Therefore it is not certified.

On September 15, 2010, , M.D., an orthopedic surgeon, performed a utilization review on the claimant. Rationale for denial: The provider failed to include interim medical reports to define the progression of the left shoulder signs and symptoms in this patient that should indicate further evaluation with the requested study. Therefore it is not certified.

PATIENT CLINICAL HISTORY:

On xx/xx/xx the claimant sustained a left upper extremity injury while participating in the movement of a large heavy pipe/hose

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

The provider failed to submit medical records that document progression of the left shoulder signs and symptoms. There is no documentation that confirms that the clamant has completed a significant course of conservative treatment. Based on the above-mentioned the previous decisions are upheld.

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- 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**

- [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)**