

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/11/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Shoulder MR arthrogram

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

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines, Shoulder Chapter, Arthrography

Chiropractors Clinic: 03/15/10

Dr. 04/14/10, 05/04/10,

MRI report: 07/09/10

Dr. Initial Evaluation: 08/10/10

Dr. Pre-Cert request for shoulder 08/11/10

Dr. Script for PT 09/23/10

Physical Therapy 09/26/10

Sports Medicine: 10/01/10, 10/21/10, 10/22/10

Dr. Designated doctor's exam: 12/14/10

FCE: 01/04/11

Dr. OV: 01/11/11, 01/20/11

Pre-cert MR arthrogram: 01/13/11, 02/17/11

Peer Reviews: 01/19/11, 02/25/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained a work related injury to her right shoulder on xx/xx/xx when her right shoulder was hit by a metal door. The claimant underwent a right rotator cuff repair of a full thickness tear with subacromial decompression on 08/26/2010.

Postoperatively, she has slowly been improving. A designated doctors' examination on 12/14/10 found her to have reached maximal medical improvement with a whole body impairment rating of 7%. When the claimant saw Dr. on 01/11/11 she had full motion passively but actively it was painful anywhere over 90 degrees and significant weakness was present. Dr. did not feel that the claimant had an appropriate course of physical therapy and recommended physical therapy and a MR Arthrogram. The MR Arthrogram was noncertified in a peer review dated 01/19/11 as the reason for suspecting additional rotator cuff tear was

not clear and an MRI was the preferred method to rule out the cuff repair rather than an MR arthrogram. The claimant next saw Dr. on 01/20/11 and complained that physical therapy actually made the shoulder pain worse. The claimant still had weakness and any active motion over 90 degrees was painful. Dr. once again recommended an MR Arthrogram. This was noncertified in a peer review dated 02/25/11 as the documentation submitted for review did not support the request.

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

On review of this case, no complications from the previous surgery were documented. There is no documentation of a new injury, which would lead one to suspect a disruption of the cuff or disruption of the repair of the cuff. In short, the Official Disability Guidelines are not satisfied for the recommendation of an MR Arthrogram given the information provided. Upon independent review, the reviewer finds that the Right Shoulder MR arthrogram is not medically necessary at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)