



Southwestern Forensic
Associates, Inc.

REVIEWER'S REPORT

DATE OF REVIEW: 01/04/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MR arthrogram, right shoulder

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in practice of Pain Management full time since 1993

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

ODG criteria have been met for the requested procedure.

INFORMATION PROVIDED FOR REVIEW:

1. TDI Referral
2. URA findings, 11-1 to 11-17-2010
3. MRI, R. Shoulder MRI, 5-6-2010
4. Health Services, PA-Lateral Chest X-ray, 6/25/2010
5. PT Associates, FCE, 9/13/2010
6. Medicine Associates, office notes, 3/19/2010 to 9/30/2010
7. University Medical Center, PT notes, 3/29/2010
8. MD, office notes, 6/11/2010 to 11/29/2010
9. Surgical Center, surgical notes, 6/29/2010
10. PT, therapy notes, 7/7/2010 to 9/1/2010

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This individual sustained a back and shoulder injury. After failure of conservative care, the claimant underwent a Mumford rotator cuff repair surgery on 06/29/10. There is persistent pain, weakness, and progressive limitation of range of motion. Postoperative physical therapy has been performed. An MRI scan shows a partial supraspinatus tear. Dr. is concerned over the persistent progressive deterioration of range of motion along with persistent pain and weakness.

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

The ODG endorses MR arthrogram to detect labral tears. This modality is more sensitive than MRI scan alone. Dr. fulfills this criteria. It is reasonable to perform an MR arthrogram of the right shoulder per ODG.

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

(Check any of the following that were used in the course of your review.)

- 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)