



MedHealth Review, Inc.

661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax 972-775-6056

Notice of Independent Review Decision

DATE OF REVIEW: 5/26/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a repeat right shoulder MRI.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a repeat right shoulder MRI.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: and MD.

These records consist of the following (duplicate records are only listed from one source):

Records reviewed from: UR referrals dated 4/7/11 to 4/14/11, patient information sheet, 4/14/11 script for MRI, office/progress notes from Orthopaedic Surgical Associates (OSA) of 10/19/10 to 4/14/11, 1/6/11 to 3/8/11 preauth requests for PT, 12/22/10 to 3/3/11 PT referrals, daily notes by Healthmasters 1/27/11 to 2/24/11, 12/17/10 right shoulder MRI report, 12/9/10 progress reports by and 10/4/10 DWC 69 and report by MD.

Dr.: all records submitted were duplicative of the above mentioned records.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This female was injured xx/xx/xx when she slipped and fell on the stairs and grabbed the rail hurting her shoulder and neck. The patient was first seen in the emergency room where the dislocated shoulder was reduced. The patient has had an MRI of the right shoulder July 23 and December 17, 2000 and with the most recent report indicating acromioclavicular arthrosis with

impingement, tendinopathy, rotator cuff partial tear, and possible chondral irregularity at the superior aspect of the humeral head noted. The patient has had physical therapy with 16 visits to December 9, 2000 and 5 visits as of January 31, 2001 her Doctor. The April 7, 2011 report by Dr. indicated the patient was doing okay therapy helping but she feels she has not advanced anymore. The only quantified examination finding was 95° active range of motion on flexion. The patient did have Hawkins test with internal rotation for supraspinatus pain and Near's test for shoulder pain and Speed' s test for biceps pain. The shoulder was injected with corticosteroid and local anesthetic. In follow-up on 4/14/11 there were no significant changes noted. The only quantified physical therapy note December 9, 2010 noted no significant change since November 17, 2010.

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

ODG On Line Edition Shoulder Chapter- 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
- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology.

The medical records provided for review do not indicate a significant change in symptoms or findings suggestive of significant pathology; therefore, the reviewer indicates that the repeat MRI of the right shoulder 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- 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)