

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/17/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of the right shoulder w/o contrast 73221

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

MD -- 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

Operative report 10/17/07

Office visit note 04/11/08

Peer Reviews 04/01/11, 04/18/11

Dr. OV 03/24/11

MD Rx 03/29/11, 04/11/11

MD pre- authorization request 03/29/11

MD fax 04/11/11

Official Disability Guidelines, Shoulder Chapter

PATIENT CLINICAL HISTORY SUMMARY

This is a male with a reported injury date of xx/xx/xx; the mechanism of injury was not provided. The records indicate that the claimant was diagnosed with left shoulder rotator cuff tear, instability and contracture. The claimant was noted to be status post left shoulder arthroscopy with repair rotator cuff tear, distal clavicle excision, subacromial decompression and debridement on 10/17/07. A physician record dated 03/24/11 noted the claimant with recurring right shoulder pain with diffuse tenderness on examination. Left shoulder examination showed atrophy of the upper extremity with decreased motion. The impression was pain in shoulder. Medication and a right shoulder MRI were recommended.

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

The MRI right shoulder w/o contrast 73221 is not medically necessary based on the records provided in this case. Office note of 03/24/11 documents diffuse tenderness about the shoulder, a positive supraspinatus test and tenderness of the subacromial space. There is not documentation of motion abnormalities or weakness. ODG advises treatment of shoulder pain initially conservatively with a corticosteroid injection and an exercise program. If this fails to provide relief or if there is significant lack of abduction on examination an MRI of the shoulder would then be indicated to look for a rotator cuff tear. According to the Official Disability Guidelines, indications for MRI includes acute trauma with the suspicion of rotator cuff tear impingement over age 40, subacute shoulder pain, suspect instability or labral tear.

In this case there is no acute trauma, no radiographs have been provided, there is no documentation of appropriate conservative care or lack of shoulder abduction. Therefore per the Official Disability Guidelines right shoulder MRI w/o contrast 73221 is not medically necessary at this time.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates
:Shoulder

Magnetic resonance imaging (MRI)

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

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)