

Wren Systems

An Independent Review Organization
3112 Windsor Road #A Suite 376
Austin, TX 78703
Phone: (512) 553-0533
Fax: (207) 470-1064
Email: manager@wrensystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/18/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right shoulder MRI

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

MD, Board Certified, Orthopedic Surgery

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, 2011 Updates, Shoulder, Indications for Imaging

Reconsideration review determination 03/03/11

Utilization review determination 02/21/11

Request for pre-authorization repeat MRI right shoulder 02/24/11

Office notes MD 12/21/10 through 02/15/11

Physical therapy progress note and discharge note 12/06/10 through 12/20/10

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xx. Records indicate the injured employee was injured secondary to lifting heavy sheets of metal. Injured employee is status post right shoulder surgery with rotator cuff repair and subacromial decompression performed 08/04/10. The injured employee participated in outpatient physical therapy. Follow up note dated 02/15/11 noted the injured employee reported his shoulder still bothers him. When he tries to do scaption or abduction at about 90 degrees he gets a lot of pain. X-rays were noted to show good position of anchors, but did not show rotator cuff tendon itself. Physical examination reported pretty significant pain in the mid arc of his scaption motion. There was some pain with rotation. Rotator strength was still down some compared to the opposite side. Patient was recommended to get MRI scan to reevaluate the rotator cuff.

A request for right shoulder MRI was reviewed by Dr. on 02/21/11. Dr. noted that repeat MRI was only recommended for significant change in symptoms and / or findings suggestive of significant pathology. Dr. noted it was unclear if either of these has occurred, and it is also unclear if the injured employee had been doing home exercise program or attending physical therapy approved in November. As such, medical necessity could not be determined.

An appeal request for right shoulder MRI was reviewed by Dr. on 03/03/11. Dr. determined the request to be non-certified, noting that with respect to repeat MRI, Official Disability Guidelines state it is not routinely recommended and should be reserved for significant change in symptoms and / or findings suggestive of significant pathology. In the injured employee's case there was no history of intervening injury or any evidence on physical

examination of impairment that would relate to pathology or postoperative complication that would require repeat MRI. It was further noted that on 12/20/10 the report states the injured employee has no pain, but the following day at orthopedic evaluation the injured employee reported "pretty severe pain."

Dr. noted absent a specific intervening injury to the shoulder and absent physical examination evidence of impairment or pathology that would necessitate repeat MRI, and further considering at least on one occasion inconsistencies were noted in the injured employee's report of pain between therapy note and orthopedic evaluation the next day, the appeal request for right shoulder MRI was not considered medically necessary.

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

The right shoulder MRI is not medically necessary. The injured employee is reported to have sustained a lifting injury on xx/xx/xx and underwent right shoulder rotator cuff repair and subacromial decompression on 08/04/10. The injured employee did participate in a course of physical therapy. Physical therapy progress note dated 12/20/10 noted the injured employee stated he has no pain, he is just sore. The next day on orthopedic evaluation the injured employee stated it still hurts a lot and has been taking some Ibuprofen. X-rays of the right shoulder noted anchors from repair appear to be in appropriate position. There was notation of pain with motion, but no detailed examination with both passive and active range of motion measurements was submitted for review. There were no special orthopedic tests documented that would indicate significant change in symptoms or findings of significant pathology. Consequently medical necessity has not been established for right shoulder MRI. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

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)