

Clear Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/09/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of the right shoulder

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

Preauthorization review determination 10/21/11

Preauthorization review determination 09/23/11

Office notes Dr. 08/05/11

Comprehensive follow-up history 08/26/11

Physical examination 08/26/11

Assessment and plan 08/26/11

Patient duty status report 12/16/11

MRI right shoulder 10/15/10

MRI lumbar spine 10/08/10

MRI pelvis 10/08/10

Electrodiagnostic findings 06/27/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male whose date of injury is xx/xx/xx. He has shoulder, back and pelvic pain. MRI of right shoulder on 10/15/10 revealed a full thickness tear of anterior supraspinatus tendon, obliquely oriented tear of superior labrum with intact biceps tendon anchor. MRI of lumbar spine on 10/08/10 revealed slightly inferiorly extruded disc herniation at L4-5 with mild compression of both L5 nerve roots and abutment of both L4 nerve roots. Posttraumatic hematoma and edema was noted in subcutaneous fat in posterior aspect of lumbosacral junction. No fractures were identified. He has a history of pubic symphysis reduction surgery on 08/11/10. He is status post right shoulder arthroscopy and open rotator cuff repair of the right shoulder. Other treatment has included chiropractic, medications, physical therapy, epidural steroid injections, corticosteroid injections to the right shoulder, and psychiatric counseling. Electrodiagnostic testing of the lower extremities performed 06/27/11 reported no clear electrodiagnostic evidence of lumbar radiculopathy. The claimant was

recommended to undergo further imaging of the lumbar spine with myelogram and post myelogram/discogram CT, and MRI of the right shoulder.

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

This patient sustained an injury on xx/xx/xx. MRI of the right shoulder revealed a full thickness tear of the anterior supraspinatus tendon and obliquely oriented tear of the superior labrum with intact biceps tendon anchor. He has undergone previous right shoulder surgery including open rotator cuff repair. There is no current physical examination of the right shoulder with objective assessment/measurement of range of motion with orthopedic testing results. There is no indication as to a proposed treatment plan for the right shoulder. As such, the reviewer finds medical necessity is not established for MRI of the right shoulder.

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)