

MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 21, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Repeat MRI right shoulder.

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

M.D., Board Certified in 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)

The requested repeat MRI right shoulder is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 11/28/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 12/29/12.
3. Notice of Assignment of Independent Review Organization dated 11/30/12.
4. Denial documentation dated 11/21/12 and 10/24/12.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury on xx/xx/xx. Denial letter dated 10/24/12 reported the patient was status post right shoulder SLAP repair on 1/13/12 and underwent 24 sessions of postoperative physical therapy. The note reported a clinical note on 7/31/12 which reported the patient complained of 6/10 pain with loss of grip strength on the right and 4+/5 right deltoid strength. The patient was recommended for shoulder MRI. A Designated Doctor Evaluation on 9/25/12 noted positive impingement signs in the shoulder with 30 degrees of abduction. The patient has requested authorization and coverage for repeat MRI right shoulder.

The URA states that the request for repeat MRI of the shoulder was denied as the Designated Doctor evaluator did not describe findings of the test and just stated “positive” or “negative.” Reconsideration determination dated 11/21/12 indicated the request for repeat MRI of the right shoulder was again not certified as the records did not report evidence of re-injury or significant clinical change in symptoms.

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

The request for repeat MRI of the right shoulder is not medically necessary based upon the documentation provided. The Official Disability Guidelines (ODG) states that repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The documentation submitted for review indicates the request has been previously denied on two occasions due to lack of documentation of findings suggestive of significant pathology or significant change in symptoms. There were no clinical notes submitted for review from the requesting provider. There was also no prior documentation of imaging studies provided for review. All told, the submitted documentation lacks evidence of significant change in the patient’s current clinical status. Therefore, I have determined the requested repeat MRI of the right shoulder is not medically necessary for treatment of the patient’s medical condition.

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 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 NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**