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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: May/16/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material

A 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that the request for magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Request for IRO dated 04/24/13

Receipt of request for IRO dated 04/25/13

MRI right shoulder dated 06/20/12

Clinical notes 07/02/12, 07/23/12, 08/27/12, 10/29/12, 11/07/12, 12/05/12, 12/19/12, 01/14/13, 02/11/13, 03/15/13, and 04/17/13

Procedure reports right shoulder injections dated 07/02/12, 07/23/12, 08/27/12, 11/07/12, 12/19/12, and 01/14/12

Operative report right shoulder dated 10/25/12

Operative report dated 03/07/13

Behavioral health evaluation dated 03/25/13

Preauthorization report dated 03/25/13

Utilization review correspondence dated 03/25/13

Utilization review correspondence dated 04/01/13

Utilization review report dated 04/02/13

Utilization review correspondence dated 04/03/13

Functional capacity evaluation results dated 03/27/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who has date of injury of xx/xx/xx. On the date of injury she was going up some stairs holding onto a rail when she slipped and fell. She is reported to have sustained a rapid hyper forward flexion of right shoulder which resulted in immediate and fairly severe right shoulder pain. She was treated with physical therapy without improvement. She was subsequently referred to who continued the claimant's conservative treatment and performed at least 3 intraarticular injections. She noted only transient relief and was

ultimately taken to surgery on 10/25/12. At this time the claimant underwent a near acromioplasty and Mumford distal clavicle resection on 10/25/12. Postoperatively the claimant was treated conservatively and underwent program of rehabilitation. She had continued limitations in range of motion. She was provided additional corticosteroid injections without substantive benefit. She was noted to have developed later complaints of low back pain with radiation into right buttocks and posterior thigh. She ultimately was returned to surgery on 03/07/13 and underwent manipulation under anesthesia. Records indicate request was placed for MRI of lumbar spine.

On 03/25/13 the request was reviewed. non-certified the request for MRI of lumbar spine. He noted there was no evidence of neurologic deficits on examination to support the performance of MRI of lumbar spine within Official Disability Guidelines. He notes deep tendon reflexes, motor, and sensory were all reported as normal or intact.

A subsequent appeal request was reviewed on 04/02/13. non-certified the appeal request. A peer to peer was performed who reported the patient did not have any radicular findings or red flag findings. He felt due to long history of pain, MRI was indicated. He notes the patient has had low back pain for quite some time without radicular findings or red flag findings that would be consistent with recommendation of Official Disability Guidelines, and as such the request was deemed not medically necessary.

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

The submitted clinical records indicate the claimant is a female who sustained a primary injury to her right shoulder. The records indicate the claimant underwent a course of conservative treatment and failed to improve and ultimately was taken to surgery. Postoperatively the claimant's recovery was confounded by development of adhesive capsulitis requiring manipulation under anesthesia. The records indicate the claimant had intermittent reports of low back pain with radiation into the right buttock and posterior thigh. There are no objective findings posted on physical examination suggestive of neural compromise. Further, the record does not indicate that plain radiographs were performed as initial assessment. As such, it is the opinion of this reviewer that prior utilization review determinations were appropriate and consistent with Official Disability Guidelines and as such the request for magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material is not medically necessary.

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)