IMedReviews
14785 Preston Road, Suite 550 | Dallas, Texas 75254
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Notice of Independent Review Decision

DATE OF REVIEW: 11/26/2014

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Ultrasound guided Injection, Left Rhomboid.

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

M.D. Board Certified in Orthopedic Surgery and Sports medicine.

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)

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a male who was injured at work on xx/xx/xx. Has had pain in the left shoulder, neck, and left arm since then associated with left arm numbness and tingling. This has been treated with medications including Norco, Tramadol, Flexeril, and ibuprofen without improvement. He has had PT and did a home exercise program which did not help. He has had both an intra-articular steroid injection as well as trigger point injections without any response. He has had MRI and CT of the left shoulder as well as an EMG of the left upper extremity. The MRI showed subacromial bursitis with outlet impingement as well as a small posterior labral tear. CT and EMG were normal. Requested treatment at this point is for an ultrasound guided rhomboid injection.

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

Per ODG references, the requested “Ultrasound guided Injection, Left Rhomboid” is not medically necessary. The patient has not had any response to any of the prior injections specifically the trigger point injections and therefore there is not an indication per guidelines to do further trigger point injections either with or without ultrasound. Request for ultrasound guided rhomboid injection is not certified.

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ 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