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Notice of Independent Review Decision

DATE OF REVIEW: 9/23/2014

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient repeat MRI arthrogram of the left 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 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]:

The patient is a female who sustained an injury to her left shoulder in a fall while at work on xx/xx/xx. She has been treated with conservative modalities including medications, injections, and physical therapy without apparent improvement. She has not had surgery. She had an MRI dated 5/2/2012 that showed calcific tendonitis of the supraspinatus with a possible partial thickness tear, greater than physiologic subacromial bursal fluid, and AC joint arthritis. No biceps or labral pathology was noted. Subsequent MRI arthrogram dated 9/12/2013 showed partial undersurface tear of the supraspinatus with a small amount of contrast in the subacromial space that was thought to be related to some contrast being injected extra-articularly but could represent a pinpoint full thickness supraspinatus tear. Per notes on 6/18/2014 the requested repeat MRI arthrogram is requested to assess for healing of the rotator cuff.



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

Per ODG references, the requested "Outpatient repeat MRI arthrogram of the left shoulder" is not medically necessary. This is on the basis that per guidelines MRI arthrogram is not indicated for assessing healing of a partial thickness rotator cuff tear. The patient has not had surgery such that this would be assessing a post-surgical situation and labral pathology is not suspected so there is no indication for repeat imaging.

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