

Notice of Independent Review Decision

DATE OF REVIEW: January 25, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Radiologic Examination, Shoulder, Arthrography, Radiological Supervision And Interpretation

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

This physician is a Board Certified Orthopedic Surgeon with 44 years of experience.

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On xx/xx/xx, an MRI of the right shoulder was performed. Impression: 1. downward sloping of the acromion with hypertrophied arthropathy of the AC joint,

and Grade I impingement of the supraspinatus, with narrowing of the supraspinatus space as interpreted M.D.

On September 15, 2010, the claimant underwent surgical intervention of the right shoulder as performed by M.D. Procedures: Right shoulder excision distal clavicle and acromioplasty.

On September 16, 2010, the claimant was evaluated by M.D. He is nauseated on his pain medications, otherwise doing well. His fingers move well. He is referred to physical therapy and was given Darvocet-N 100.

On September 22, 2010, the claimant was re-evaluated by M.D. He is noticing drainage from his wound. There is no purulence and no surrounding erythema. There is no infection; he was placed on Clindamycin 300 mg.

On September 23, 2010, the claimant was re-evaluated by M.D. He is developing blisters from the taping which need to be monitored.

On September 24, 2010, the claimant was re-evaluated by, M.D. There is no more drainage. His flexion is 70 degrees and abduction is 50 degrees.

On October 1, 2010, the claimant was re-evaluated by M.D. His wound is doing much better since the staples have been removed. He is to continue physical therapy.

On October 12, 2010, the claimant was re-evaluated by Physical Therapy Today. He demonstrates improved limitations with functional mobility and tolerance to daily activities. Patient is unable to perform active movement at this time. Reports improved independence with grooming, dressing, and bathing but continues to have limitations. He will benefit from skilled physical therapy to address his functional deficits. He will continue physical therapy three times a week for four weeks.

On October 13, 2010, the claimant was re-evaluated by M.D. He reports a burning sensation at his incision. His flexion is 150 degrees and abduction is 145 degrees. He is given a new prescription for physical therapy to allow him to begin strengthening and to advance as tolerated.

On November 1, 2010, the claimant was re-evaluated by M.D. There has been no drainage. He is concerned because he had an incident when his daughter hit him on his shoulder and he has increased pain. He has had 14 visits of physical therapy. His passive range of motion is 105, abduction is 95 degrees. He is concerned about a painful catch as his arm descends from an elevated position. A steroid injection would not be feasible this soon after surgery; an MR Arthrogram is recommended as he continues to have ongoing difficulties.

On November 17, 2010, the claimant was re-evaluated by M.D. He reports aggravation of pain; it has been more and more severe. A PT note states he has paresthesia and sharp pain. His passive flexion is 145 degrees and abduction is 155 degrees. Active flexion is 105 degrees and abduction 95 degrees.

On November 24, 2010, M.D., an orthopedic surgeon, performed a utilization review on the claimant. Rationale for Denial: The patient already had an MRI showing no tear. There was surgery that showed no tear. There was no new injury. There are no exam findings consistent with a tear. The MRI arthrogram is no medically necessary based on records reviewed. Therefore, it is not certified.

On December 10, 2010, M.D. an orthopedist performed a utilization review on the claimant Rational for Denial: The patient has undergone a prior MRI of the right shoulder that revealed no evidence of rotator cuff tearing or labrum tear. There is also no mention of rotator cuff tearing in the prior operative report. There are no post operative physical exam findings that would indicate evidence of a rotator cuff or labrum tear. Therefore, it is not certified.

PATIENT CLINICAL HISTORY:

This is a male.

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

The previous decisions are upheld as the MRI from 8/6/10 did not reveal a tear of the rotator cuff and there is no mention of rotator cuff tearing in the 9/15/10 operative report. Furthermore, there are no physical findings on suggestive of a rotator cuff tear in the medical records supplied for review.

Per ODG:

Arthrogram (Shoulder)

Recommended as indicated below. Magnetic resonance imaging (MRI) and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific. Magnetic resonance imaging may be the preferred investigation because of its better demonstration of soft tissue anatomy. ([Banchard, 1999](#)) Subtle tears that are full thickness are best imaged by arthrography, whereas larger tears and partial-thickness tears are best defined by MRI. Conventional arthrography can diagnose most rotator cuff tears accurately; however, in many institutions MR arthrography is usually necessary to diagnose labral tears. ([Oh, 1999](#)) ([Magee, 2004](#)).

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 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)