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Notice of Independent Review Decision

DATE OF REVIEW: 7/13/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a right shoulder MR Arthrogram (73222).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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 reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a right shoulder MR Arthrogram (73222).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker was injured on xx/xx/xx . The claimant's ongoing severe shoulder pain has been noted. The 2/15/11 dated exam findings discussed diffuse tenderness and a positive painful provocative maneuver at the biceps tendon. The 12/8/10 dated shoulder cyst aspiration was noted. The 11/3/10 dated arthrogram injection was noted. The 8/10/10 dated note documented that the DOI was xx years ago and that the diagnosis was a complete rotator cuff tear. On 7/8/08, the claimant was noted to be s/p 2 arthroscopic surgeries, including debridement, labral repair and decompression.

An MRI-arthrogram dated 11/3/10 showed tendinosis of the rotator cuff with a partial midsubstance tear within the supraspinatus tendon. There is a recurrent posterior superior labral tear with a paralabral cyst and a capsular defect. There is tendinosis of the long head of the biceps and subscapularis. Treatment has included medications, therapy, and a prescribed home exercise program.

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

Specific objective physical findings (or changes for the worse) which would warrant another MR arthrogram have not been submitted. Therefore, without such clinical findings, with a history of prior surgical repairs (without a subsequent acute injury mechanism), a prior MRI-arthrogram with already known findings, without any change or documented physical exam findings between the 2/11 and 5/11 note, and, without recent x-rays, MR arthrogram is not medically reasonable or necessary as per applicable guidelines.

Reference: ODG Shoulder Chapter Indications for imaging -- Magnetic resonance imaging (MRI):

- Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs
- Subacute shoulder pain, suspect instability/labral tear
- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology.

Arthrography-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. 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.

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)