

IRO Case # 41146

June 5, 2012

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Notice of Independent Review Decision

DATE OF REVIEW: June 5, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of Left Shoulder. CPT Code: 73221.

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

DIPLOMATE, AMERICAN BOARD OF ORTHOPAEDIC SURGERY
FELLOW, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Carrier include:

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PATIENT CLINICAL HISTORY:

To Whom It May Concern:

I have had the opportunity to review medical records on this patient. The records indicate a date of injury of xx/xx/xx and include a reported injury to the left shoulder. The purpose of the review is to determine the medical necessity of an MRI of the shoulder. The records indicate that the patient sustained a left rotator cuff tear on xx/xx/xx, while attempting to stop an individual from falling.

The patient underwent arthroscopic left rotator cuff repair on December 2, 2011.

The patient underwent physical therapy following the surgery. There were a total of 22 supervised physiotherapy visits performed.

Because of higher than normal levels of pain, a subacromial injection was performed in March of 2012.

There was additional physical therapy requested. The patient was making gains in range of motion and pain, but strength was lagging.

There was an MRI requested by M.D. A repeat MRI was non-certified by the carrier, citing a peer review by M.D. The reviewing physician found no medical indication consistent with the ODG Guidelines to perform a repeat MRI. There was an additional review performed by Glen Smith, D.O. It was also his recommendation to non-certify a repeat MRI. He recounted the above history and noted that the ODG Guidelines for repeat MRI had not been met. The repeat non-certification of the MRI was appropriate.

The patient underwent a successful rotator cuff repair on December 2, 2007. He developed post surgical limitations in range of motion. Office visits are reviewed.

Dr. noted significant stiffness and adhesive changes on February 28, 2012, which were not present previously. There was an injection performed at that visit. He did get significant initial relief from the injection. Further physical therapy was prescribed.

The patient returned to see Dr. on April 24, 2012. Dr. noted active elevation of 110 degrees and external rotation of 10 degrees. There was no evidence of reflex sympathetic dystrophy. There was mild swelling in the hands. There was a subacromial injection performed at that time.

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

There is no medical indication for a repeat MRI. The ODG Guidelines do not support the need for a repeat MRI. The patient appears to have problems with stiffness following arthroscopic rotator cuff repair. There is no indication in the records of a recurrent rotator cuff tear. The denial by the carrier is appropriate.

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)