

True Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Nov/08/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI Arthrogram left shoulder

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

Board Certified Orthopedic Surgeon (Joint)

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 medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Postoperative physical therapy reports dated 10/24/04 – 06/10/05

Radiographs of the chest dated 09/14/04

MRI of the left shoulder dated 08/02/04

MR arthrogram of the left shoulder dated 09/08/04

MR arthrogram of the left shoulder dated 03/15/05

Designated Doctor Evaluation dated 02/10/05

Peer review dated 11/06/12

Required Medical Exam dated 08/07/13

Handwritten clinical report dated 09/20/12

Clinical reports dated 07/23/04 – 06/02/05

Clinical report dated 08/12/13

Appeal letter dated 04/20/13

Operative report dated 09/16/04

Anesthesiology reports dated 09/16/04

Prior reviews dated 08/19/13 & 09/17/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx when he fell landing on the knees on left arm. The patient developed pain within the left shoulder and is status post left shoulder rotator cuff repair and partial acromionectomy performed on 09/16/04. The patient did have extensive postoperative physical therapy performed through June of 2005. The last

imaging study provided for review was from 03/15/05. The left shoulder MR arthrogram showed adhesive capsulitis and postoperative changes without evidence of a rotator cuff re-
tear. The patient was discharged from active treatment in June of 2005. The patient did
report complaints of left shoulder pain in September of 2012 and the physical examination at
this date did demonstrate loss of range of motion in the left shoulder on extension in all
planes. The patient was recommended for repeat arthrogram studies of the left shoulder at
that visit. The Required Medical Exam completed on 08/07/13 indicated the patient had
difficulty with the left shoulder. Physical examination did show mild weakness at the left
shoulder on strength testing with loss of range of motion in all planes. Some mild crepitation
with left shoulder range of motion was noted. The patient did report pain with impingement
testing. felt that it was reasonable for the patient to have a repeat MR arthrogram for the left
shoulder due to the recurrence of severe symptoms. The clinical evaluation on 08/12/13
stated that the patient continued to have complaints of left shoulder pain. Physical
examination continued to show severe tenderness to palpation over the supraspinatus
insertion as well as at the lateral acromion. There was severe limited range of motion with
pain. Impingement signs could not be performed due to severe pain; however, there was a
markedly positive Hawkins' sign and weakness was noted with Jobe's testing.

The requested MR arthrogram was denied by utilization review on 08/19/13 as there were no
objective findings for possible labral pathology that would support the requested imaging
study.

The request was again denied by utilization review on 09/17/13 as there was no evidence
regarding possible labral injury that would reasonably require repeat MR arthrogram studies.

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

The patient presented with a recurrence of severe left shoulder pain without evidence of
interval trauma. The patient's most recent physical examination findings showed severe loss
of range of motion in the left shoulder with markedly positive impingement signs. Based on
the 08/12/13 exam, there was severe pain with Jobe's relocation testing which is concerning
for anterior shoulder instability. Given this finding for instability and the patient's ongoing
severe pain in the left shoulder, it is this reviewer's opinion that there is sufficient evidence
regarding possible instability to warrant MR arthrogram studies of the left shoulder. As such,
it is this reviewer's opinion that medical necessity for the request is established and the prior
denials are overturned.

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

**[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH
ACCEPTED MEDICAL STANDARDS**

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES