

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Apr/05/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of the 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

MRI left shoulder dated 07/24/12

Clinical notes from Dr. dated 08/10/12 – 03/06/13

Prior reviews dated 01/11/13 and 02/28/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx while lifting. The patient fell and injured his left shoulder. Initial MRI studies of the left shoulder completed on 07/24/12 identified a 1.5 cm full-thickness tear involving the anterior leading edge of the supraspinatus tendon. There was intrasubstance strain and intrasubstance tearing of the posterior half of the tendon. Intrasubstance tearing was also identified at the infraspinatus and teres minor tendons. There was 25% thickness tearing of the distal subscapularis tendon. No glenoid labral tearing was identified and there was no significant anterior acromial downsloping. The patient's initial orthopedic exam on 10/08/12 revealed loss of range of motion in the left shoulder with flexion no more than 100 degrees and pain with limited external and internal rotation. The patient was recommended for surgical intervention regarding the left shoulder.

The patient is noted to have undergone a left knee arthroscopy. The patient was recommended for further MRI studies of the left shoulder on 01/07/13 to establish the current condition of the rotator cuff tearing and if the rotator cuff tearing could be repaired. Dr. opined on 02/20/13 that the patient should have updated imaging studies of the left shoulder to determine the status of the rotator cuff tearing before any surgical intervention. Follow-up on 03/06/13 stated that the patient did have some improvements in regards to the left shoulder but continued to have severe pain. Physical examination revealed significant loss of range of motion with positive impingement signs.

The request for a MRI of the left shoulder was denied by utilization review on 01/11/13 as there was no indication of any significant change in symptoms, any new injuries, or findings suggestive of significant pathology.

The request was again denied by utilization review on 02/28/13 as there were no significant changes noted that would require repeat imaging studies.

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

The patient has had persistent pain in the left shoulder that has substantially increased over time. The initial imaging studies of the left shoulder did identify a significant rotator cuff tear fully involving the supraspinatus tendon with partial-thickness tearing noted in the remaining rotator cuff tendons. The patient was initially recommended for surgical intervention; however, the left knee was addressed first. As it has been 6 months since the initial imaging and given the extent of the rotator cuff tearing noted on initial imaging, a repeat MRI study would be reasonable and medically necessary to evaluate the current status of the rotator cuff and to determine if a rotator cuff repair could even be performed. An updated MRI study would be able to show whether a graft jacket can be completed for the rotator cuff tears. The patient's physical examination findings also identified significant loss of range of motion that appears even worse than the initial evaluations. Given this progressive change over time and based on the need for updated evaluation of the rotator cuff, it is this reviewer's opinion that medical necessity is established for the request and the prior denials are overturned.

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

ACOEM-AMERICA 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

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE A DESCRIPTION)