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Notice of Independent Review Decision

Date: August 1, 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:
Certified by the American Board of Orthopaedic Surgery
Recertified by the American Board of Orthopaedic Surgery, 2011
Orthopaedic Sports Medicine Subspecialty CAQ, ABOS, 2011

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Office visits (06/29/12 – 05/14/13)
- Diagnostic study (08/24/12)
- Procedures (11/26/12)

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- Procedure (11/26/12)
- Office visits (12/04/12 – 05/14/13)
- Physical therapy (02/06/13 – 03/20/13)
- Utilization reviews (03/14/13, 05/20/13, 06/04/13)

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ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who on xx/xx/xx, was driving heavy machinery. His friend was also driving heavy machinery and hit the patient. The patient's head went back and broke the window and his left lower extremity hit the dashboard of the machine. He lost consciousness. On xx/xx/xx, the patient had a second accident. He was on light duty. He was on top of a machine when he slipped and fell to the ground (5-6 feet) and landed on the left side of his body.

2012: On June 29, 2012, an orthopedic surgeon, evaluated the patient for low back pain, left elbow aching and moderate pain radiating into the left shoulder and left hip pain radiating into the left knee. The patient reported that he had 12 visits of physical therapy (PT) for the elbow that did not help. He underwent eight visits of PT for the knee without any improvement. The patient also had 12 visits for the shoulder that did not help. Examination of the left shoulder showed supraspinatus tenderness and positive Hawkin's test, Neer's test and empty can sign. Muscle strength testing showed flexion 4/5, external rotation at 0 degrees of abduction 4/5 and abduction of 4/5. Examination of the lumbar spine showed tenderness at the paraspinal region from L3 to L5 and paraspinal trigger point pain. diagnosed sprains and strains of the left shoulder and upper arm, rotator cuff (capsule), contusion of the back, contusion of the knee and contusion of the left elbow. He reviewed the computerized tomography (CT) scans and outside records and recommended a PT program and x-rays of the lumbar spine, left shoulder, left elbow and left knee at the next visit.

On July 13, 2012, evaluated the patient for pain in the lumbar spine, left knee, left shoulder and left elbow. obtained x-rays of the left knee that were unremarkable. X-rays of the lumbar spine, left shoulder and left elbow were also unremarkable. diagnosed contusion of the knee, contusion of the back, sprains and strains of the shoulder and upper arm, rotator cuff (capsule) and left elbow contusion. He noted that the shoulder was bothering the patient most. He prescribed Celebrex and Ambien, recommended CSI, magnetic resonance imaging (MRI) scan for further evaluation, starting a PT program and follow-up in four weeks.

On August 10, 2012, evaluated the patient for mild-to-moderate pain in the left knee, left shoulder, left elbow and low back. noted that PT had been denied. The patient had significant rotator cuff weakness and signs and symptoms of a rotator cuff tear. He recommended an MRI scan to evaluate the rotator cuff tear.

On August 24, 2012, MRI of the left shoulder showed: (1) Partial articular-sided (rim rent) tear of conjoined tendon (supraspinatus/infraspinatus). (2) Superior labral tear extending from anterior to posterior. (3) Mild tendinosis supraspinatus and infraspinatus with no full-thickness rotator cuff tear, joint effusion or narrowing of the supraspinatus outlet.

On August 31, 2012, reviewed the MRI findings that confirmed partial rotator cuff tear and superior labrum anterior posterior (SLAP) lesion. He recommended surgical intervention to include scope, subacromial decompression, SLAP repair and possible rotator cuff repair.

On November 26, 2012, performed arthroscopic repair of SLAP labral tear, arthroscopic debridement of partial rotator cuff tear and arthroscopic subacromial decompression.

On December 4, 2012, noted that the patient was currently in a sling. His weakness was decreasing. Postoperative examination showed limited active and passive motion. noted that the patient was doing well. He recommended shoulder immobilizer and starting PT. The patient was placed on light duty.

On December 18, 2012, noted that the patient had moderate pain when trying to sleep at night. Examination showed limited passive and active motion. The patient was doing well, but had not yet begun PT. recommended starting PT as soon as possible.

2013: On January 22, 2013, the patient was seen. He was in a sling and had mild swelling and moderate pain when doing physical therapy (PT) sometimes. He complained of neck pain. He was taking Lortab for pain and still had continuous passive motion (CPM) machine at home. On examination, the passive and active motions were limited. diagnosed sprains and strains of the shoulder and arm [rotator cuff (capsule)] and sprains and strains of the shoulder and upper arm [superior glenoid labrum lesion]. He stated the patient was doing well two months postoperatively and recommended advanced PT and CPM, and discontinuing the sling. He placed the patient on work with restrictions through February 19, 2013, with no lifting greater than ten pounds and no pushing/pulling with the left arm. Follow-up was recommended in four weeks.

On January 27, 2013, on examination noted no swelling, tenderness or warmth, although the passive and active motion was still limited. His diagnoses remained the same. He recommended active and passive range of motion (ROM) as tolerated as well as stretching, scar massage and advancement to strengthening as tolerated.

On February 6, 2013, a PT evaluation was performed. The patient was noted to have attended 17 sessions of PT with modalities including therapeutic activities/exercises, manual therapy, a hot/cold pack and therapeutic procedures. Through February 12, 2013, 19 sessions of PT are documented.

On February 19, 2013, the patient returned stating that with hydrocodone he had mild pain in the left shoulder; however, weakness was decreasing. He had been going to PT three times a week and stated that he had noticed increased neck and right shoulder pain the last couple of weeks. The patient had been advised by PT that this was likely due to overcompensation. recommended continuing use of CPM machine and PT with active ROM as tolerated and stretching, scar massage and strengthening as tolerated. He was recommended PT three times a week for four weeks. In regards to the superior glenoid labrum lesion, the patient was improving gradually but still had limited motion. Unfortunately, the CPM had been taken away despite the last note which stated that he wanted the patient to

continue it. Now he was progressing very slowly and may be losing ground. , therefore, wanted him to restart CPM and continue PT for aggressive ROM. If he did not regain his motion in the next three to four weeks, then a manipulation under anesthesia (MUA) would be considered. recommended follow-up in three weeks and continued the patient's work restrictions through March 12, 2013.

As of March 1, 2013, there are 27 sessions of PT documented at Physical Therapy. The modalities included therapeutic activities/exercises.

On March 12, 2013, noted that PT had significantly helped the patient with certain ROMs but he still had pain and trouble with strengthening. Lortab was helping him. The patient needed a work excuse. Examination of the left shoulder revealed external rotation at 0 degrees of abduction (45 degrees) and 90 degrees of abduction (30 degrees); internal rotation at 90 degrees of abduction to be 20 degrees, abduction (120 degrees), and forward flexion (135 degrees). Passive ROM was as follows: external rotation at 90 degrees of abduction (30 degrees) and 0 degrees of abduction (45 degrees); internal rotation at 90 degrees of abduction 20 and limited, abduction (120 degrees) and forward flexion (135 degrees). Special tests on the left: Hawkin's test positive, Neer's test and empty can sign test positive; O'Brien's test and Speed's test negative and subscapularis strength test was normal. Strength on the left: abduction was -4/5, flexion was -4/5, and external abduction 5/5, internal rotation 5/5 and scapular elevation 5/5. continued Lortab 5/500 mg, recommended shoulder MUA and referred the patient for PT that was to begin on the same day as surgery. He also recommended a CPM machine to the left shoulder to advance as tolerated immediately postoperatively. noted that the ROM was not improving and was even worse since the last visit. The patient was struggling to regain his motion likely due to PT starting a full month late and discontinuation of CPM prematurely. He therefore recommended MUA to regain ROM and CPM and PT immediately.

On March 14, 2013, an orthopedic surgeon, denied the request for outpatient left shoulder MUA based on the following rationale: "*Based on Official Disability Guidelines (ODG), manipulation under anesthesia cannot be supported. The claimant is status post on November 26, 2012, SLAP and rotator cuff repair procedure. There is no indication of postoperative injections with the most recent progress report indicating 120 degrees of abduction to the shoulder. The ODG only recommends the role of manipulation under anesthesia that is recalcitrant to care for six months where restricted abduction of less than 90 degrees is present. Given less than six months of treatment since the time of rotator cuff repair and 120 degrees of abduction on current examination, the role of the proposed procedure cannot be supported as medically necessary.*"

On March 20, 2013, the patient was seen and noted to have completed four sessions of PT since December 19, 2012, with the modalities including manual therapy, neuromuscular re-education, therapeutic activities/exercises, hot/cold packs and electrical stimulation. It was recommended that the patient continue therapy for a total of 12 weeks with PT twice a week for four weeks.

On March 27, 2013, requested authorization for additional therapy.

On March 29, 2013, the patient returned stating that PT helped him a little. Examination of the left shoulder were as follows: Active ROM: external rotation at 0 degrees of **abduction (45 degrees) and 90 degrees of abduction (30 degrees)**; internal rotation at 90 degrees of **abduction (20 degrees)** abduction of 120 degrees and forward flexion of 120 degrees. Passive ROM: external rotation at 90 degrees of adduction (45 degrees) and 0 degrees of abduction (45 degrees), internal rotation at 90 degrees of abduction 20 and limited, abduction 135 degrees and forward flexion 135 degrees. Strength in the left was abduction -4/5, flexion -4/5, external rotation at 0 degrees of abduction 4/5 and adduction 5/5, extension 5/5, external rotation at 90 degrees of abduction 5/5, internal rotation 5/5 and scapular elevation 5/5. stated the request for MUA and PT had been denied. The patient had ultrasound-guided CSI on that day. He still had issues with ROM and pain. felt that postoperative course would have been much better if he was approved for PT in the earlier postoperative period. He recommended a home exercise program (HEP) and follow-up in four weeks. The patient was to work with restrictions through May 14, 2013.

On May 14, 2013, noted PT had helped the patient a little with strengthening but not with pain. Previous injections had given him relief for a few hours (24 hours then the pain returned to normal). Lortab was helping him. discussed that the CSI in the last visit had not helped the pain for more than few days. The stiffness had improved since the last visit, but the pain and weakness was still quite symptomatic. continued Lortab and recommended obtaining a new MRI of the left shoulder to evaluate the rotator cuff.

Per utilization review dated May 20, 2013, the request for MRI of the left shoulder was denied, with the following rationale: *"I discussed this case, who reports the claimant continues to have pain in the shoulder. The claimant has not improved in physical therapy. The claimant does not think he has a recurrent tear, but is unclear as to the cause of the pain. This request is not certified. The guidelines indicate that an MRI is recommended for acute shoulder trauma where there is a suspicion of a rotator cuff tear or impingement with normal plain radiographs and for subacute shoulder pain where there is a suspicion of instability. The guidelines state repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The medical documentation provided for review documents the claimant has previously undergone a left shoulder arthroscopy, subacromial decompression, SLAP repair, debridement, and repair of rotator cuff on November 26, 2012. The most recent clinical note reported physical therapy has helped with strength, but no pain. Per the documentation provided, active range of motion has improved in physical therapy. There is no indication in the medical documentation provided for review that there has been a significant change in symptoms or findings suggestive of significant pathology. Based upon the medical documentation provided for review and the peer-reviewed evidence-based guidelines, the request is not medically supported. The request for MRI for the left shoulder is not certified."*

Per utilization review dated June 4, 2013, the appeal was denied, an orthopedic surgeon with the following rationale: *"This is a male claimant who reported a slip and backward fall on xx/xx/xx. Diagnoses included left shoulder pain, partial rotator cuff tear, SLAP tear and impingement syndrome. A left shoulder MRI performed on August 24, 2012, showed a partial tear of the supraspinatus/infraspinatus tendon, superior labral tear and mild tendonitis. The claimant was noted to be status post left shoulder arthroscopy with subacromial decompression and SLAP repair November 26, 2012. Initial postoperative physician records noted the claimant attending physical therapy with left shoulder weakness improving and limited motion. The claimant treated with a sling, medication and light duty. A physician record dated May 14, 2013, revealed the claimant with continued left shoulder pain and weakness still quite symptomatic. Hawkins/Neer/Empty can signs were positive with strength 4/5. MRI of the left shoulder has been requested. The request for left shoulder MRI was previously denied on May 23, 2013, per peer review as the request did not meet guideline criteria, as there were no significant changes in symptoms suggestive of significant pathology. An attempt was made to speak but was unsuccessful. Thus, without speaking to the physician, the MRI cannot be approved based on the information provided. There is not any clear indication of a change in the clinical condition such that would warrant additional imaging beyond that done in August of 2012."*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The claimant underwent a SLAP repair with "debridement" of a suspected partial thickness rotator cuff tear on 11/26/12, and has had pain and limited ROM since, improving to some degree but with persistent symptoms.

It appears that a postoperative MRI has been requested. A routine MRI is inappropriate for evaluation of the SLAP repair or the rotator cuff after surgery, as it is less sensitive and less specific than a MR-arthrogram, which would be the more appropriate study—UNLESS the nonarthrogram MRI is being performed on a 3 Tesla scanner (a 3T scanner would produce results of similar sensitivity and specificity as a MRA on a smaller magnet). There is no indication in the records herewith that the routine MRI ordered was to be performed on a 3T magnet. The denial is upheld.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**