

# IRO Express Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

Jun/28/2013

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI (plain, right 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

Utilization review determination dated 03/29/13, 05/09/13

Office note dated 03/21/13, 11/27/12, 11/13/12, 10/16/12, 09/04/12, 08/16/12, 07/10/12, 06/21/12, 05/10/12, 04/19/12, 03/22/12, 02/23/12, 02/14/12, 02/02/12, 01/26/12, 12/29/11, 12/01/11, 10/25/11, 10/06/11

Operative report dated 10/01/12, 11/16/11

MRI right shoulder dated 08/28/12, 09/22/11

Handwritten physical therapy initial evaluation dated 10/10/12, 11/28/11

Physical therapy discharge summary dated 01/29/13, 04/04/12

### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the patient fell off a ladder sustaining an injury to his right shoulder. The patient underwent right shoulder arthroscopy on 11/16/11 with subacromial decompression and distal clavicle excision followed by postoperative physical therapy. MRI of the right shoulder dated 08/28/12 revealed near full-thickness tear of the supraspinatus at the critical zone over a 14mm anterior posterior distance with a few bursal sided fibers intact; no tendon retraction and supraspinatus muscle belly is normal. There is mild distal infraspinatus tendinosis without a tear. There is moderate subacromial/subdeltoid bursitis. The patient subsequently underwent diagnostic arthroscopy of the right shoulder with revision distal clavicle excision. Note dated 11/13/12 indicates he is sore, but is much better than before surgery. On physical examination right shoulder range of motion is full. Follow up note dated 03/21/13 indicates he is not in any

significant pain. He does have good range of motion, but still feels weak when he lifts anything 10-20 pounds at the waist or above his head. On physical examination right shoulder has full range of motion. He has 4/5 external rotation. Impingement signs are negative.

Initial request for right shoulder MRI was non-certified on 03/29/13 noting that Official Disability Guidelines state that repeat MRIs are not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The patient has done well status post revision surgery to the right shoulder. The patient reported no significant pain and had full range of motion on last clinical note. There were no significant physical exam findings to suggest significant underlying pathology. It appears that the requesting provider is recommending the study based on the patient's desire to have an MRI prior to returning to work. The denial was upheld on appeal dated 05/09/13 noting that on 11/27/12 noted he recommended the patient should go back to full duty work but the patient was adamant and did not want to until another MRI and indicated he was not sure that it was necessary. The March 21, 2013 office noted full range of motion with 4/5 external rotation and negative impingement signs. The current medical records do not offer information supporting the need for a repeat MRI of the shoulder as there are no significant functional deficits post surgical repair of the shoulder that would support the need for the repeat study.

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

The patient sustained an injury to the right shoulder on xx/xx/xx and is status post right shoulder arthroscopy x 2. The Official Disability Guidelines state that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The most recent office visit note submitted for review dated 03/21/13 states that the patient is not in any significant pain. He does have good range of motion, but still feels weak when he lifts anything 10-20 pounds at the waist or above his head. On physical examination right shoulder has full range of motion. He has 4/5 external rotation. Impingement signs are negative. Therefore, the submitted records fail to document a significant change in symptoms and/or findings suggestive of significant pathology. As such, it is the opinion of the reviewer that the request for MRI (plain, right shoulder) is not recommended as medically necessary.

**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**