

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Sep/17/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI right shoulder

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

Board Certified Orthopedic Surgeon

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

MRI of the right shoulder dated 07/25/12

Clinical note dated 08/13/12

Operative report dated 08/22/12

Clinical note dated 08/29/12

Clinical note dated 10/03/12

Clinical note dated 11/28/12

Clinical note dated 02/04/13

Designated doctor examination dated 02/10/12

Clinical note dated 08/05/13

Clinical note dated 08/12/13

Prospective review response dated 09/02/13

Previous adverse determinations dated 08/12/13 & 08/21/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury regarding his right shoulder when he fell and landed on his right shoulder on xx/xx/xx. The MRI of the right shoulder dated 07/25/12 revealed a full thickness tear of the rotator cuff. The clinical note dated 08/13/12 reports the patient complaining of right shoulder pain. The patient was noted to be utilizing over the counter Motrin at that time. Upon exam, tenderness was noted upon palpation. The tenderness was primarily located over the acromioclavicular joint and the lateral acromion. Strength deficits were noted with external rotation and abduction that were rated as 4+/5.

The operative report dated 08/22/12 reported the patient undergoing a right sided rotator cuff repair. The clinical note dated 08/29/12 reports the patient presenting for a postoperative follow up. The incisions were noted to be healing well with no drainage. No signs of infection were noted. The patient was recommended to initiate physical therapy at that time. Per the clinical note dated 10/03/12, the patient reported mild postoperative pain but was continuing to make good progress with therapy. The clinical note dated 11/28/12 notes the patient complaining of mild ongoing shoulder pain. The patient was able to demonstrate 160 degrees of flexion and 50 degrees of external rotation. The patient was continuing with physical therapy at that time. Per the clinical note dated 02/04/13, the patient reported ongoing soreness at the shoulder. Strength deficits were noted with external rotation and abduction. The patient was recommended to continue with physical therapy at that time. The designated doctor exam dated 02/10/12 mentions the patient having undergone 5 months of conservative care with some progress. The patient rated his pain as 9/10 and described it as a sharp, shooting, stabbing, burning, dull pain. Physical activities and lifting objects exacerbated the pain. The clinical note dated 08/12/13 mentions the patient being recommended for a repeat MRI at that time.

The utilization review dated 08/12/13 resulted in a denial for an MRI of the right shoulder as the patient's clinical exam revealed good range of motion with only mild weakness.

The utilization review dated 08/21/13 resulted in a denial for an MRI of the right shoulder as no substantial changes were noted over the previous 6 months. The claimant was also noted to have good range of motion with only mild weakness.

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

The documentation submitted for review elaborates the patient complaining of right shoulder pain despite a previous surgical intervention. An MRI of the right shoulder would be indicated provided the patient meets specific criteria to include findings consistent with a rotator cuff tear or impingement and previous radiographs are noted to be normal or the patient is noted to have the possibility of instability or a labral tear. No information was submitted regarding any clinical findings that would indicate a rotator cuff tear. Additionally, no information was submitted confirming a possible impingement or instability. Given that no significant clinical findings indicating a possible rotator cuff tear or impingement or the possibility of instability noted at the right shoulder, this request is not indicated. As such, it is the opinion of this reviewer that the request for an MRI of the 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:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES