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Notice of Independent Review Decision

Date notice sent to all parties:

November 25, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MR Arthrogram of the 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female with a date of injury of xx/xx/xx. On 06/20/14, she presented to the clinic with right shoulder pain rated 7/10. She stated she felt a pop in her right shoulder with immediate pain to her clavicle. Upon physical examination, she had well healed arthroscopic incisions and had tenderness about the sternoclavicular joint and anterior/posterior aspects. Range of motion was limited but she had no instability. She had positive impingement sign with mildly positive drop arm sign and compression test. On 07/10/14, a pre-authorization determination letter stated that the requested service, MRI arthrogram of the right shoulder, was non-certified. It was noted the patient previously had undergone a MRI of the right shoulder and repeat imaging studies would have been indicated provided that the patient met special specific criteria, including significant changes

in symptoms or development of new pathology by clinical evaluation. The previous MRI was not submitted for review and it was unclear if the patient developed any new pathology or significant changes with symptoms. The request was non-certified. On 07/11/14, a revised non-certification letter noted a case conference was held with the requesting physician but the decision had not changed. On 09/09/14, the patient returned to clinic and physical examination remained essentially unchanged. A MR arthrogram of the right shoulder was recommended. On 09/24/14, a utilization review determination stated the requested MR arthrogram of the right shoulder was not medically necessary as the previous MRI was not provided for review and the patient did not meet the criteria as there was no indication of significant changes in symptoms or development of new pathology that would warrant a repeat study.

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

The previous determinations have been based on lack of clinical information, as the previous MRI was not provided, and it was not documented that the patient has sustained new pathology or that her symptoms had changed. The clinical records indicate that the patient was seen on 06/20/14 and 09/09/14 and the examination of her right shoulder remained essentially unchanged. The previous MRI of the right shoulder was not provided for this review. The clinical notes do not indicate significant changes in symptoms or new pathology or new injuries. The provider indicates that the patient has positive impingement sign and does not indicate that she that there is question of whether she has labral tear. Guidelines indicate that MR arthrogram may be considered reasonable at times to diagnose labral tears and MRI may be the preferred tool because of its better demonstration of soft tissue anatomy. The records do not indicate a rationale for repeat exam at this time and recommendation is the MR Arthrogram of the right shoulder is not medically necessary.

IRO REVIEWER REPORT TEMPLATE -WC

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

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

Indications for imaging -- Magnetic resonance imaging (MRI):

- Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs
- Subacute shoulder pain, suspect instability/labral tear
- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008)

Arthrography

Recommended as indicated below. Magnetic resonance imaging (MRI) and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific. Magnetic resonance imaging may be the preferred investigation because of its better demonstration of soft tissue anatomy. (Banchard, 1999) Subtle tears that are full thickness are best imaged by arthrography, whereas larger tears and partial-thickness tears are best defined by MRI. Conventional arthrography can diagnose most rotator cuff tears accurately; however, in many institutions MR arthrography is usually necessary to diagnose labral tears. (Oh, 1999) (Magee, 2004)