14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

DATE OF REVIEW: 12/22/2013

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI Arthrogram Right Shoulder

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

M.D. Board Certified in Orthopedic Surgery and sports Medicine Orthopedic.

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

Document Type	Date(s) - Month/Day/Year
Department of Insurance Notice of Case Assignment	12/02/2013
Utilization Review Determinations	10/15/2013-10/30/2013
Operative Report Radiology Report	7/23/2013 6/07/2013
Clinical Notes	7/24/2013-11/11/2013

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who injured his right shoulder at work on xx/xx/xx when he slipped and caught himself with his right arm. He subsequently reinjured his shoulder while catching himself after slipping on xx/xx/xx. He was initially evaluated on 6/21/13 and found to have a right shoulder full thickness tear in his supraspinatus, AC joint hypertrophy consistent with arthrosis, and impingement based on findings on an MRI dated 6/17/13. He subsequently underwent a right shoulder surgery for a rotator cuff repair, acromioplasty, and distal clavicle resection on 7/23/13. There are notes from 7 post op visits over the following 3 months with the most recent dated 10/14/13. Based on these notes the patient appears to be progressing in terms or range of motion in PT. The exam findings are not extensively documented but his shoulder function seems to be improved compared to pre-op with the ability to raise his arm overhead to touch the back of his head and the ability to reach his opposite shoulder documented in post op notes when he could not do these things pre-op. There is clinical documentation of a subjective pinch in the shoulder in the last 2 post-op notes but there are no physical exam findings related to this or further description of this. MRI arthrogram of the right shoulder is requested to evaluate his healing progress in relation to this pinching

14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

complaint and to assess healing to allow for progression to work conditioning or a functional capacity evaluation.

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

Per ODG references, the requested "MRI Arhtrogram Right Shoulder" is not medically necessary. Based on the clinical notes it appears the patient was progressing on a normal post-operative course and was improving. There is no documentation from the clinical notes that the patient has had a new injury, is regressing in PT, or has any physical exam findings consistent with a persistent or recurrent rotator cuff tear. Also the last note is dated around 3 months after the surgery and based on the clinical timeframe required for recovery from a rotator cuff repair the patient is not yet to the point that repeat imaging would be necessary outside the setting of a new injury or an abrupt change in his exam or symptoms. As for using the arthrogram to evaluate healing, there is not an indication for routine use of MRI arthrogram to assess healing in making determination for progression in PT or activity level. This is generally done based on expected timeline for healing and based on the patient's clinical progression in terms of symptoms and physical exam without the need for imaging. For these reasons the MRI arthrogram of the right shoulder is not certified.

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

- ☐ 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
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES