

Icon Medical Solutions, Inc.

11815 CR 452
Lindale, TX 75771
P 903.749.4272
F 888.663.6614

Notice of Independent Review Decision

DATE: December 7, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat MRI Arthrogram Left Shoulder to Include CPT Code 73222

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

The reviewer is certified by the American Board of Orthopaedic Surgery with over 42 years of experience.

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

02/20/13: MRI Left Shoulder Without Contrast report
02/28/13, 04/04/13, 05/16/13, 06/06/13, 06/13/13, 06/24/13, 07/15/13, 08/23/13, 10/04/13, 11/15/13: History and Physical Exam
05/18/13: Updated Plan of Care
06/04/13: Operative Report
06/26/13, 07/26/13, 08/30/13, 10/24/13: Updated Plan of Care
10/07/13: Letter by
10/10/13: UR performed
11/01/13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who injured her left shoulder while working on xx/xx/xx. She is status post left shoulder surgery.

02/20/13: MRI Left Shoulder without Contrast report. IMPRESSION: Moderate infraspinatus hypertrophic tendinosis with a bursal sided partial-thickness tear at the critical zone measuring 9.5 mm AP by 5.7 mm right to left, involving

approximately 70% of tendon thickness with a normal associated muscle belly. Mild infraspinatus tendinosis without a tear. Mild sub acromial/subdeltoid bursal fluid/edema. Mild-moderate traction spurring, capsular hypertrophy and reactive edema at the acromioclavicular joint.

02/28/13: The claimant was evaluated for left shoulder pain. She localized the pain to the left subacromial space, in the left subdeltoid area and on the left shoulder. She rated her pain as 8/10. The pain occurred when lifting, pushing, and certain movements and at night. On physical exam, Hawkin's and Neer's were positive. There was pain with external rotation. Speed's and Yergason's tests were markedly positive. Scapular dysrhythmia was present. X-rays of the left shoulder, there was mild AC joint arthritis. No significant glenohumeral arthritis. No superior humeral head migration, no subluxation, no dislocation and no fracture. MRI of the left shoulder showed partial thickness supraspinatus tear –high grade – likely full thickness component. PLAN: Begin physical therapy. Use NSAIDS. Left SA cortisone injection given.

04/04/13: The claimant was reevaluated. She stated that the injections helped with the left shoulder pain. The plan was to continue therapy and surgery if not improved after therapy.

06/04/13: Operative Report. POSTOPERATIVE DIAGNOSIS: Left shoulder partial-thickness rotator cuff tear. Left shoulder biceps tendinitis. Left shoulder labral tear. Left shoulder adhesive capsulitis. PROCEDURES: Arthroscopy of the left shoulder with rotator cuff repair. Arthroscopic subacromial decompression of the left shoulder. Arthroscopic capsular release of the left shoulder. Left open subpectoral biceps tenodesis.

06/24/13: The claimant was evaluated postoperatively. She was doing well with pain rated at 5/10. Medications included Norco. On physical exam, her incisions were healing well. She had slightly restricted range of motion and clinically improving. She was counseled regarding the need to wear a sling and continue home exercises.

08/23/13: The claimant was reevaluated. She stated that she was doing better with pain rating at 3/10. On physical exam, ROM was acceptable at this postop visit and clinically improving. PLAN: Begin strengthening. May use NSAIDS prn. Warned about lifting too much as her tendon was only 50% strong. Continue to stretch.

08/30/13: The claimant was evaluated. It was noted that she had 80% perceived improvement in pain with limitations in reaching forward, overhead, and behind back. PROM: Flexion 150 degrees, abduction ER 40 degrees, IR 70 degrees. Shoulder flexion 3/5 strength, IR 4-5/, ER 4-/5. Limitation with SH rhythm and shoulder flexion with compensation. ASSESSMENT: has made some improvements in ROM however remains to have limitations in functional strength needed for job and self care. Will continue to benefit from skilled PT. Patient response to therapy: excellent. Continue PT 2 days per week x 4-6 weeks.

10/04/13: The claimant was evaluated for left shoulder pain rated 2/10, mild, described as constant. Medications included Tramadol and Norco. On physical exam, active humeral elevation was 150 degrees, active external rotation with the arm at the side was 40 degrees, internal rotation was to the mid lumbar. Elevation strength was 5/5, external rotation strength 5/5. Hawkin's was mildly positive. Neer's mildly positive. Pain with resisted external rotation was present. Pain to capsular stretch was markedly positive. PLAN: Based on her failure to improve, wanted to obtain an MRI Arthrogram.

10/07/13: Letter. "The patient is a lady who underwent a left shoulder rotator cuff repair/subacromial decompression/capsular release, and open biceps tenodesis on 06/04/13. The patient has had persistent pain despite physical therapy. It has been over four months since her surgery and she is still having significant pain. Therefore, it is necessary to obtain an MRI arthrogram to evaluate the rotator cuff healing. Without this MRI, I cannot tell whether or not her surgery was successful. I disagree with the denial letter. I would like her chart and my findings and recommendations to be reviewed by a person who specializes in shoulder surgery."

10/10/13: UR performed. RATIONALE: Postop rehab has been provided with improvement. 10/04/13 note documents 2/10 pain, 150 degrees of elevation, 5/5 motor testing, and residual decreased external rotation and pain with capsular stretch. There is not a clear indication for repeat imaging.

11/01/13: UR performed. RATIONALE: I talked and we was concerned about the claimant's persistent subjective complaints of pain and a possible re-tear of her rotator cuff. The records indicate that the pain was mild (2/10). There was normal strength at 5/5 and a very functional range of motion with 150 degrees of elevation. I do understand concerns but with minimal pain and a functional range of motion, it would be very difficult to justify an MRI arthrogram at this time.

11/15/13: The claimant was evaluated for left shoulder pain rated 2/10 with limited range of motion and intermittent aching. Medications included Tramadol and Norco. On exam, active humeral elevation was 130 degrees, active external rotation with the arm at the side 30 degrees, and internal rotation was to the lumbosacral spine. Elevation strength was 5/5, external rotation strength 5/5. PLAN: noted that he thought her pain was certainly stiffness. He noted that her post-surgery MRI arthrogram was denied and that they may pursue legal action to get it approved. He showed her posterior capsular stretching. Continue aggressive HEP. RTC in six weeks.

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

The previous adverse decisions are upheld. With the claimant's postop function and range of motion as well as pain relief, it would be expected that she should have a very good result from her surgery. I would recommend further observation. Only if her condition deteriorates would an MRI and possible further

surgery be indicated. Per ODG repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or finding suggestive of significant pathology. The claimant does not meet these requirements. Therefore, the request for Repeat MRI Arthrogram Left Shoulder to Include CPT Code 73222 is not medically necessary.

ODG:

Magnetic resonance imaging (MRI)	<p>Indications for imaging -- Magnetic resonance imaging (MRI):</p> <ul style="list-style-type: none"> - 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)
MR arthrogram	<p>Recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair. MRI is not as good for labral tears, and it may be necessary in individuals with persistent symptoms and findings of a labral tear that a MR arthrogram be performed even with negative MRI of the shoulder, since even with a normal MRI, a labral tear may be present in a small percentage of patients. Direct MR arthrography can improve detection of labral pathology. (Murray, 2009) If there is any question concerning the distinction between a full-thickness and partial-thickness tear, MR arthrography is recommended. It is particularly helpful if the abnormal signal intensity extends from the undersurface of the tendon. (Steinbach, 2005) The main advantage of MR arthrography in rotator cuff disease is better depiction of partial tears in the articular surface. (Hodler, 1992) It may be prudent to include an anesthetic in the solution in preparation for shoulder MR arthrography. (Fox, 2012) See also Magnetic resonance imaging (MRI).</p>

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- 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 (PROVIDE A DESCRIPTION)**