

Vanguard MedReview, Inc.

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Notice of Independent Review Decision

December 18, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat Right Shoulder MRI

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

This physician is Board Certified in Physical Medicine and Rehabilitation with over 18 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:

05/21/12: Operative Report
01/29/13: Report of Medical Evaluation
09/24/13: Progress Note
09/30/13: UR completed
10/21/13: UR completed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx when she strained her right shoulder. According to the Designated Doctor report a MRI of the right shoulder was performed on 02/16/12 that revealed moderate supraspinatus tendinosis with superimposed small full thickness tear at the anterior tendon footprint; Mild infraspinatus tendinosis; Mild acromioclavicular arthrosis with mild undersurface spurring; Small glenohumeral joint effusion and small fluid collection within the subacromial-subdeltoid bursa. An EMG/NCV was also reported to have been completed on 02/14/13 that showed compromised C7-8 nerve root affecting the right upper extremity similar to those seen in cervical radiculopathy of mild to

moderate degree. Treatment included 3 weeks of physical therapy prior to surgery and 7 weeks of physical therapy following surgery which improved her condition. Also 1 Trigger Point Injection to the right shoulder.

05/21/12: Operative Report. Postoperative Diagnosis: Right shoulder rotator cuff tear with associated impingement. Operation Performed: Right shoulder arthroscopic subacromial decompression and arthroscopic rotator cuff repair.

01/29/13: Report of Medical Evaluation, a Designated Doctor who opined the claimant reached MMI on 12/20/2012.

09/24/13: Progress Note for continued shoulder and neck pain post rotator cuff surgery. Pain was described to be in the area of the neck and upper margin of the scapula. No improvement was indicated with medications. Physical Exam: FROM of shoulder without crepitus or pain. Negative impingement sign. Some tenderness and pain to palpation throughout the shoulder region. Normal neuro, motor function, and strength. Assessment: 1. Shoulder pain. 2. Cervical strain. Plan: MRI right shoulder and cervical spine.

09/30/13: UR completed. Rationale for Denial: 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 patient's most recent exam from 09/24/13 indicated that her right shoulder has full range of motion without crepitus or pain; negative impingement sign; some tenderness to palpation throughout the shoulder region; full range of motion with pain in the cervical area; reflexes equal bilaterally. The documentation submitted for review fails to support the request as the patient has already had an MRI of the shoulder with subsequent surgical intervention and met maximum medical improvement on 12/23/12. Since that time there have been no significant changes in symptoms and or findings suggestive of pathology in the right shoulder. Clinical documentation submitted for review fails to indicate exceptional factors to warrant non-adherence to guideline recommendations.

10/21/13: UR completed. Rationale for Denial: No updated documentation was provided that addresses the previous reasons for request denial. Guidelines state that repeat MRI should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The most recent examination documented did not indicate any significant pathology in the right shoulder to warrant a repeat MRI at this time.

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

Denial of repeat shoulder MRI is upheld/agreed upon since there are no significant changes in symptoms or physical findings to suggest significant pathology. Recent exam is essentially normal with full shoulder range of motion and strength. The request for Repeat Right Shoulder MRI does not meet ODG criteria and therefore is not found to be medically necessary.

PER ODG:

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)

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 KNOWLEDGBASE
- 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)