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Notice of Independent Review Decision

DATE OF REVIEW: 10/6/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of Right Shoulder MR Arthrogram.

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

The reviewer is a Medical Doctor who is board certified in 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)

The reviewer agrees with the previous adverse determination regarding the medical necessity of Right Shoulder MR Arthrogram.

A copy of the ODG was not provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

was injured when he reportedly sustained a pulling and over extension injury to his right shoulder. Persistent pain and abnormal exam findings resulted in an MRI scan of the right shoulder dated December 20, 2013. This reportedly revealed a superior labral /SLAP and biceps anchor tears. Tendinopathy of the rotator cu was also noted. Treatments included medications, restricted activities and a cortisone injection. The claimant underwent a right shoulder arthroscopic surgery with labral repair on February 15, 2014. Despite postoperative

medications and therapy, provider records (including from July 17, 2014) documented persistent pain and grade 4+/5 strength in the supraspinatus portion of the rotator cuff. A degree of muscle atrophy was also noted. Denial letters noted the lack of significant weakness or deficits and functional range of motion. Recurrent pathology was felt unlikely. Records from August 14, 2014 discussed persistent "pain in the shoulder and instability. He feels weak in that arm." There was noted to be 4+/5 strength in the right shoulder along with a painful impingement test. Abduction was 160° and flexion was 170°. There was no muscle atrophy. The indication for the requested diagnostic tests was noted to "see if the labrum has healed in or not." The claimant has reportedly not returned to full duty.

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

The claimant has been documented to have persistent pain and instability in the affected right shoulder. The condition has not responded to the passage of a significant period of time, restricted activities, medications and therapy. The claimant has a persistent functionality deficit. The residual subjective and objective findings post significant labral tear/repair has persisted despite extensive treatments. The combination of the requested tests are reasonable and medically necessary to assess for a plausible subtle tear of the labrum in particular.

Reference: ODG Shoulder Chapter

MR Arthrogram: 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)

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)