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DATE NOTICE SENT TO ALL PARTIES: Feb/08/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Repeat MRI left shoulder

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Orthopedic Surgery

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that the request for repeat MRI left shoulder is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: Patient is a male. On XX/XX/XX, an MRI of the left shoulder was obtained revealing mild supraspinatus tendinosis, without franc rotator cuff tear or muscle atrophy. There was a complete disruption of the proximal long head of the biceps tendon. There was fraying of the posterior superior glenoid labrum suggestive of a degenerative tear. There was also AC joint osteoarthritis. On XX/XX/XX, the patient was seen in clinic for left shoulder pain and he noted he had popped his biceps lifting heavy equipment. He was referred for possible surgery to the long head of the biceps. On exam, he had normal range of motion and strength of his left shoulder. X-rays showed no fractures and no significant degenerative changes but did show a type 2 acromion. Outpatient rehab was recommended. On XX/XX/XX, the patient returned to clinic and reported continued pain and weakness in his left shoulder. On exam, impingement signs were positive and he had weakness in abduction. It was noted that the MRI from July was reviewed, showing the suggestion of a partial articular surface supraspinatus tear not called by the radiologist. A repeat MRI on a high field magnet was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On XX/XX/XX, a notification of adverse determination was submitted for repeat MRI of the left shoulder and the request was reviewed per Official Disability Guidelines. It is noted the submitted documentation indicated the patient had weakness with abduction but did not state the quantitative value of weakness to show increased weakness to support a repeat study.

On XX/XX/XX, a notification of reconsideration determination, also citing Official Disability Guidelines, stated the request was non-certified, as the physical examination report did not fully suggest a rotator cuff tear.

The guidelines indicate that repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings to suggest significant pathology. The provider has stated that the patient has pain and weakness in the shoulder not completely objectively identified and/or specific to the rotator cuff. There was known

pathology for a biceps tendon rupture.

It is the opinion of this reviewer that the request for repeat MRI left shoulder is not medically necessary and the prior denials are upheld.

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

ACOEM-AMERICA 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)