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IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
MRI XX/XX

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX-year-old XX who alleges an injury on XX. XX was XX and the XX and XX got a XX in the XX and down the XX to XX XX.

On XX, x-rays of the XX XX were performed for clinical indication of XX pain. The impression was illegible.

On XX, XX, evaluated the patient for XX XX pain and XX pain. The patient had no pain or functional limitation in the past. The pain was described as sharp and stabbing. The associated symptoms included numbness, tingling and weakness. The patient had been treated with XX XX. Surgical history was positive for XX surgery (XX) and XX surgery-dislocated XX and tendon

damage (XX). Medical history was pf XX and XX. Examination of the XX XX/XX XX showed tenderness to palpation of the lateral point of the XX. There was XX and mild tenderness to palpation. There was mild joint line tenderness. The patient had guarded active range of motion (ROM) but had full passive ROM with XX. The strength was guarded -4/5 in all plane. The patient had XX empty can, Neer/Hawkins, O'Brien and Lift Off test. The diagnoses were a tear of the XX XX, pain in XX XX, XX pain, primary XX of the XX XX, XX of XX XX and XX (DJD) of the XX region. The patient was started on XX and increase ROM out of the XX. The patient was recommended to proceed with MRI given failure to improve with rest and activity modification.

On XX, the patient underwent MRI of the XX XX. Clinical indication for the study was XX XX pain for approximately XX weeks. The study showed very extensive XX tear with retraction with muscle volume loss of the XX, XX and XX muscles. No intact XX tendon was seen in the XX groove. There was very high grade attenuating partial thickness tear of the XX tendon. The XX the undersurface of the XX. There was associated os XX defect with associated XX without significant adjacent abnormal marrow signal.

On XX, XX, evaluated the patient for XX XX pain. The pain was intermittent, sharp and stabbing for the past XX weeks. The patient reported the XX XX pain was radiating down the XX to the XX. The pain was worse with twisting, turning, pushing and lifting. The associated symptoms included numbness, tingling, weakness and XX XX. The examination of the XX XX showed tenderness over XX. Forward elevation was 120 degrees, external rotation was 80 degrees, internal rotation was 70 degrees and abduction was 100 degrees. The patient had positive Neer and Hawkins impingement test. The strength of the XX was 3+/5 with pain. The diagnosis was a tear of the XX XX XX. The patient was recommended a course of physical therapy with possible steroid injection. The patient may need XX debridement if XX failed conservative management but it was highly likely that the XX XX was not repairable due to the chronic appearance of the tear. The patient might need reverse XX XX in the future but XX was XX XX and XX XX for that operation at that point.

On XX, XX evaluated the patient for ongoing XX XX pain. The patient had been participating in PT. XX reported no change in symptoms. The patient continued to have pain and weakness. The examination of the XX XX showed tenderness over XX. Forward elevation was 90 degrees, external rotation was 80 degrees, internal rotation was 70 degrees and abduction was 90 degrees. The patient had XX Neer and Hawkins impingement test. The strength of the XX XX was 3+/5 with pain. The diagnosis was a complete tear of the XX XX XX. The patient was recommended XX, decompression and possible XX XX repai.

On XX, XX noted the patient continued to have pain which limited activities of daily living. The patient had a designated doctor exam which indicated that the patient's injury was a worsening of a previous XX XX tear and would benefit from scope. The physical examination was same as the previous visit. The patient was recommended arthroscopy of the XX with debridement and possible partial repair of the XX XX.

On XX, XX saw the patient in a postoperative follow up visit. The patient had undergone XX XX XX,

SAD and RCR on XX. The patient was doing ok and reported pain was well controlled. The patient was not taking XX. The patient was in a XX. The patient was advised to continue using XX for XX more weeks and start PT after XX weeks. The patient was to perform very gentle pendulum exercises.

On XX, XX noted the patient had not started PT yet but was doing pendulum swings and figure 8s at home. XX was wearing the XX at all time. XX reported having a lot of pain in XX that radiated to the XX and up XX with swelling in a first and second XX. The patient stated XX could not XX anything with that XX. The patient was advised to avoid lifting overhead, away from the body, or more than XX pounds. The patient was advised to continue PT.

On XX, XX noted the patient reported severe swelling and pain in the XX XX for past X-X weeks. It was worse at XX and was preventing XX from XX. The patient stated the pain travelled up XX XX. The patient complained of burning pain which radiated up and down the XX. The patient was doing PT. On examination, the patient had a XX XX swelling and inability to make a full fist. The patient had limited ROM of the XX. There was mild XX of the XX. The diagnoses were swelling of the XX, a complete tear of XX XX XX and status post XX of the XX XX. XX ordered venous ultrasound of the XX XX extremity to evaluated for possible DVT. XX opined the patient might be developing early XX (XX). XX recommended considering XX if ultrasound was negative.

On XX, XX noted the patient was doing ok as far the XX was concerned, but XX was still having swelling and severe pain in the XX and XX. The patient felt the pain sometimes goes up to the XX and under the XX. The patient reported since XX started taking the XX, XX was able to get a little more XX, but XX still woke up XX-XX times during the night. XX was still taking XX with some relief. The patient was doing PT and seemed to be limited to what XX could do because of XX XX pain and swelling. XX was unable to make a XX or carry anything with the XX XX. XX physical therapist had recommended to have XX XX evaluated and possibly obtaining magnetic resonance imaging. The patient did report some pain along the XX side of the XX. XX had pain in the XX after the injury when XX hurt XX XX. XX actually had x-rays of the XX XX at the time of injury. On examination, the BMI was 39.60. The incisions were healed. The forward elevation was 120 degrees. XX XX strength was 4/5. There was moderate swelling of XX with XX of XX. XX had radicular pain with rotation of the XX XX. The diagnoses were a complete tear of the XX XX XX, status post arthroscopy of the XX XX, swelling of the XX and XX radiculopathy. The patient was advised to continue with PT for strengthening. XX opined the patient had radicular symptoms of shooting pains down the XX which had not improved with XX. XX had failed non-steroidal anti-inflammatory drugs (NSAIDs) as well. XX had significant XX pain as a result of the original injury and had x-rays at that time. XX ordered MRI of the XX XX to evaluate for radiculopathy as a cause of the persistent postoperative pain radiating down the XX. XX also had therapy focus on the XX over the past few visits since this was the area bothering XX most.

Per utilization review dated XX, the request for MRI of the XX XX was denied based on the following rationale: *"Regarding the request for MRI of the XX XX, the claimant is status post XX XX XX repair (XX) on XX and there is swelling and severe pain in XX and XX. The pain sometimes goes up to*

the XX and under the XX. On exam, there is pain along the side of the XX. There are no clinical findings documented to suggest the need for XX XX MRI. No clear complaints of radicular pain, no neurologic exam is provided. No specific physiologic evidence of nerve dysfunction is noted. There is no indication that plain x-rays have been taken. Medical necessity was not established. Recommended non-certification. Peer to peer calls was unsuccessful.

Addendum: The case was discussed with XX, who called on behalf of physician on XX at XX. XX. Reviewed guidelines and rationale regarding XX MRI for XX. No plain x-rays and no therapy specific for XX apparently performed. no objective, reproducible radicular findings documented, no sensory loss in a dermatomal pattern, no hyper-reflexivity, no bowel, bladder findings, no reflex loss in a XX pattern, and others (etc.). Gave nurse fax number and Review ID number to fax additional information if available. Reviewed guidelines and rationale regarding this diagnoses from this date of injury, and treatment thus far. No new extenuating circumstances identified. No change in recommended determination."

On XX, an unknown provider requested for MRI of the XX XX.

Per Reconsideration review dated XX, the appeal for MRI of the XX XX was denied based on the following rationale: *"The record indicate that the patient had radicular symptoms of shooting pain down the XX XX which had not improved with medication. The patient was noted to have significant XX pain and an MRI was recommended to evaluate for radiculopathy. However, there were no red flags noted on physical examination suggestive of severe neurologic deficits to support the request. In agreement with the prior determination, the request for MRI of the XX XX without contrast is non-certified."*

Per utilization review dated XX, the request for MRI of the XX XX was documented. Determination: *No objective changes.*

On XX, XX noted the patient was still doing PT. They were working on XX strengthening and XX stabilization in therapy. The patient stated XX XX was feeling fine, but XX continued to have swelling in XX and could not use it due to the pain. XX complained of burning pain in the XX and XX. XX was on XX but ran out for a few days and had significant increase in pain without the XX. XX also reported XX had an aching pain on the XX side of the XX and had a burning stabbing pain in the XX XX. The pain radiated up the XX into the XX of the XX and gave XX XX almost every day. Examination of the XX revealed significant XX tenderness. XX had spasm in this region as well. XX had pain radiating into the XX XX with ROM of the XX XX. Examination of the XX XX revealed forward elevation to 170 degrees, external rotation to 80 degrees. The strength of the XX XX musculature was 4+/5. XX had significant swelling and weakness in the hand. The diagnoses were a complete tear of XX XX XX status post arthroscopy of XX XX and XX radiculopathy. The patient was advised to continue XX and XX. XX recommended obtaining MRI of the XX XX as XX had some radicular type symptoms and had failed rehabilitation type exercise for XX XX XX. XX did report XX pain initially as a result of XX work-related injury.

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

The XX MRI is indicated.

The previous two preauthorization denials do not appear to have been properly formulated based on the details of the records herewith.

ODG Indications for XX MRI:

XX

X Medically Necessary

☐ Not Medically Necessary

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**