

# **MATUTECH, INC.**

**DATE OF REVIEW:** APRIL 5, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

MRI of the right of the shoulder

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

The physician providing this review is a physician, doctor of medicine. The reviewer is national board certified in physical medicine and rehabilitation. The reviewer is a member of American Academy of Physical Medicine and Rehabilitation. The reviewer has been in active practice for twenty-three years.

**REVIEW OUTCOME**

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

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

Star Comprehensive Solutions:

- Office notes (09/25/06 – 02/08/07)
- Procedure note (07/20/06)
- Radiodiagnostics (06/05/06 – 02/08/07)

**PATIENT CLINICAL HISTORY:**

This is a patient who sustained an injury to her right shoulder . The following day, magnetic resonance imaging (MRI) of the right shoulder showed rotator cuff tendinopathy with mild subacromial bursitis and a probable tiny focal at least undersurface tear of the distal supraspinatus tendon, but with the possibility of a subtle full-thickness rotator cuff tear not excluded. On July 20, 2006, M.D., performed arthroscopic subacromial decompression and mini-open rotator cuff repair of the right shoulder. The post-operative diagnosis was a right shoulder rotator cuff tear.

In September, M.D., evaluated the patient and noted that she had been through physical therapy (PT) for post repair strengthening and had been doing well. However, her physical therapist had noted some possible capsulitis developing in the right shoulder. Dr. decided to give the patient one more month of PT. During follow-up a month later, good improvement was noted and Dr. continued lifting restrictions. Towards the end of November, the patient continued to have

difficulty lifting her arm above her head with difficulty reaching back. Dr. continued lifting restrictions.

In January 2007, Dr. referred the patient to Dr. for persisting shoulder discomfort and to determine if any further treatment would benefit her. In February, Dr. evaluated the patient and noted that she appeared to be doing fine at work although she was unable to lie on her right side. Right shoulder x-rays showed minimal acromion curvature with no migration of the humeral head evident. Dr. decided to request a right shoulder MRI to check the integrity of healing.

On February 19, 2007, an addendum report indicated that the shoulder MRI had been denied. The rationale apparently provided was: *Absence of records from Dr.'s office.* On March 21, 2007, request for shoulder MRI was once again denied. The rationale was: *The claimant had a normal post-operative course and returned to work full time. The request for the repeat MRI was based on the fact that the claimant still had some discomfort at night... The request for a repeat study did not meet the clinical criteria warranting a repeat study. Physical examination was essentially negative.*

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

Based on the records available it appears the patient has actually recovered quite well and pain when "laying" on a shoulder seven months post rotator cuff repair is not unusual. There is no evidence of instability or worsening of the condition and the rationale for repeat MRI is not supported by the evidenced based guidelines, in this case ODG.

**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)**