

# P-IRO Inc.

An Independent Review Organization

1507 Frontier Dr.

Arlington, TX 76012

Phone: 817-235-1979

Fax: 866-328-3894

## **DATE OF REVIEW:**

JUNE 12, 2007

## **IRO CASE #:**

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

MRI of the shoulder with and without contrast

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

Board Certified Orthopedic Surgeon

## **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 or not medical necessity exists for each of the health care services in dispute.

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

Cervical spine x-rays, 06/27/97

Notes, 07/08/97, 07/28/97, 08/22/97, 10/16/97, 12/17/97, 04/07/98, 05/18/98, 08/12/98, 12/04/98, 08/15/03, 09/09/03, 11/11/03, 12/19/03, 01/19/04, 04/20/04, 05/20/04, 08/23/04, 09/07/04, 09/27/04 and, 01/29/07

Cervical spine MRI, 09/18/97 and 10/02/02

Letter of medical determination, 10/20/97

Letters of medical necessity, 11/20/97, 12/10/97 and 02/20/98

Cervical myelogram, 02/06/98

Office note, Dr. 02/27/98

Letter to Case Manager, 04/10/98

Operative report, 04/27/98, 02/01/99, 12/08/03, 02/16/04 and 04/06/04

HEALTH AND WC NETWORK CERTIFICATION & QA 10/1/2007

IRO Decision/Report Template- WC

Right shoulder x-ray, 07/20/98  
Discharge note, 02/02/99  
Notes, physical therapy, 02/10/99 to 06/02/00  
Maximum medical improvement note, 01/12/02  
Office note, Dr. 09/12/02  
Office note, Dr. 02/24/03  
Office note, Dr. 05/02/03, 02/17/04  
Office notes, Dr. 11/20/03, 01/20/04 and 08/05/04  
MRI with and without contrast, 01/27/04  
ENT consult, Dr. 04/01/04  
Office note, Dr. 04/04/07  
Appeal letter, claimant, 05/14/07  
Independent review summary, 05/22/07

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is currently a female, formerly employed as a customer service manager for a large retail chain. The claimant reportedly injured her neck and both shoulders in a fall on xx/xx/xx. Prior to the fall, the claimant underwent a cervical fusion at C6-C7 in 1995.

The claimant continued with complaints of neck and left shoulder pain despite injections and therapy after her fall. On 04/27/98, she underwent left shoulder arthroscopic subacromial decompression. Right shoulder pain persisted. An MRI of the right shoulder on 08/12/98 noted a small rotator cuff tear. On 02/01/99, the claimant underwent arthroscopic subacromial decompression to the right shoulder.

The claimant continued with complaints of neck and upper extremity radicular symptoms. Cervical spine MRI on 10/02/02 noted early spinal stenosis at C3-4 and C4-5 with bilateral neuroforaminal narrowing at C5-6. An orthopedic visit with Dr. on 02/24/03 noted that motion in both shoulders was good. The opinion was that most of the claimant's shoulder complaints were due to the cervical disc disease.

The claimant treated with pain management and underwent several cervical epidural blocks and selective epidural neurolysis. A repeat cervical MRI on 01/27/04 noted disc herniation at C5-6 with nerve root encroachment and central canal stenosis. On 04/06/04, the claimant underwent a cervical fusion at C5-C6.

On 01/29/07, the claimant presented with complaints of right shoulder pain and weakness. The records provided did not indicate any new injury or trauma. X-rays noted some bone spurs on the inner surface of the acromion. On exam, there was some weakness with abduction and internal and external rotation. The impression was possible rotator cuff tear and surgery was recommended.

On 04/04/07, Dr. requested a right shoulder MRI.

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

This claimant apparently sustained multiple injuries in a fall. She underwent left shoulder arthroscopy with subacromial decompression in April of 1998 and subsequently right shoulder arthroscopic subacromial decompression on 02/01/99. The claimant's

treatment then focused on her cervical disc disease with documented pathology on imaging and underwent cervical fusion on 04/06/04.

The claimant presented on 01/29/07 with ongoing complaints of right shoulder pain and weakness. The clinical examination findings noted some weakness with motion but no indication of the claimant's current functional deficit and no documentation of any positive provocative testing. There is no mention of any conservative care measures including therapy and injection. The request on 04/04/07 was for a right shoulder MRI. The medical records provided for review do not support the medical necessity for an MRI of the shoulder at this time. It is not clear by the documentation how long the claimant's current right shoulder symptomatology has been present. There is no documentation or evidence in the records that the claimant has any symptoms indicative of a full thickness rotator cuff tear to support the necessity of an MRI to make that diagnosis prior to surgery.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates (shoulder)

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

**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)**