

# **RYCO MedReview**

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**DATE OF REVIEW:** 05/14/07

**IRO CASE #:**

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

MRI of the left shoulder with contrast

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

Board Certified in 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 or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Evaluations with M.D. dated 08/31/05, 10/07/05, 10/21/05, 11/11/05, 03/03/06, 03/14/06, 03/28/06, 04/07/06, 04/13/06, 04/27/06, 05/11/06, and 08/30/06  
MRIs of the left shoulder and cervical spine interpreted by, M.D. dated 09/13/05  
An operative report from Dr. dated 03/31/06  
An impairment rating evaluation with Dr. dated 07/13/06

A Designated Doctor Evaluation with Dr. (no credentials were listed) dated 09/11/06

Evaluations with D.C. dated 10/04/06, 11/17/06, and 03/19/07

An EMG/NCV study interpreted by Dr. (no credentials were listed) dated 10/13/06

An impairment rating reconsideration letter from Dr. dated 10/20/06

A physical therapy referral from M.D. dated 11/06/06

Chiropractic therapy with Dr. dated 11/27/06, 12/13/06, and 03/19/07

An unreadable letter from L.L.C. dated 12/13/06

A letter of denial from D.C. dated 01/16/07

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

On 08/31/05, Dr. recommended continued physical therapy, an MRI of the cervical spine and left shoulder, and a Medrol Dosepak. An MRI of the left shoulder interpreted by Dr. on 09/13/05 revealed tenosynovitis of the rotator cuff with impingement. An MRI of the cervical spine interpreted by Dr. on 09/13/05 revealed minimal spondylosis and disc bulging. On 12/02/05, Dr. continued physical therapy. Dr. performed left shoulder surgery on 03/31/06. On 07/13/06, Dr. placed the patient at Maximum Medical Improvement (MMI) and assigned him an 8% whole person impairment rating. On 09/11/06, Dr. placed the patient at MMI with a 6% whole person impairment rating. On 10/04/06, Dr. requested further therapy. An EMG/NCV study interpreted by Dr. on 10/13/06 revealed right C6 radiculopathy. On 11/17/06, Dr. requested further physical therapy. Chiropractic therapy was performed with Dr. on 11/27/06, 12/13/06, and 03/19/07. On 01/16/07, Company wrote a letter of denial for a left shoulder MRI. On 03/19/07, Dr. recommended a chronic pain management evaluation.

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

This patient has a history of a left shoulder injury that had a previous MRI and then he underwent surgery. The patient initially did well, but now continues to have pain. The treating doctor wants to order a repeat MRI to evaluate the previous surgery and see whether there is any type of injury. In my opinion, this would be an appropriate use of an MRI in which the ODG and ACOEM supports, especially to evaluate postoperative shoulder injury and to evaluate pain that did not get better as one would expect after surgery.

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

**X 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)**