

Notice of Independent Review Decision

DATE OF REVIEW: 1/7/2008
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

72141: Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material

QUALIFICATIONS OF THE REVIEWER:

This reviewer attended San Diego State University before graduating from the Palmer's College of Chiropractic West in 1989. He has been in private practice in San Diego County for over 14 years. He also works as a team chiropractor for a local high school. He has also worked as a peer reviewer doing Worker's Compensation and Personal Injury Prospective, Retrospective, Forensic, and Chart Reviews since 10/2000. His post graduate studies include various seminars on cervical spine "whiplash" syndrome, arthritis, neurology, radiology, sports medicine, and worker's compensation.

REVIEW OUTCOME:

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

<input checked="" type="checkbox"/> Upheld	(Agree)
<input type="checkbox"/> Overturned	(Disagree)
<input type="checkbox"/> Partially Overturned	(Agree in part/Disagree in part)

72141: Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Review organization dated 12/20/2007
2. Adverse determination letter dated 12/05/2007 and 12/17/2007
3. Request form dated 12/19/2007
4. Reviews of case assignment by dated 12/20/2007
5. Clinical note dated 12/26/2007
6. Notice to utilization by, dated 12/20/2007
7. Determination letter dated 12/5/2007
8. Pre-authorization request dated 12/26/2007
9. Clinical note dated 12/26/2007
10. Operative report by MD, dated 7/13/2006
11. MIR of the right shoulder by MD, dated 2/28/2007
12. Clinical note dated 3/15/2007
13. Clinical note dated 10/26/2007
14. Determination letter dated 12/17/2007
15. Determination letter dated 12/17/2007
16. Pre-authorization request dated 12/26/2007
17. Clinical note dated 12/26/2007
18. Evaluation of permanent impairment by MD, dated 3/13/2007
19. MRI of the right shoulder dated 2/28/2007
20. Operative report by MD, dated 7/13/2006
21. Clinical note by MD, dated 3/15/2007
22. Clinical note dated 10/26/2007
23. Clinical note dated 6/25/2007
24. Adverse determination letter dated 12/5/2007
25. Clinical note dated 12/26/2007
26. Adverse determination letter dated 12/5/2007
27. Report of medical evaluation dated 3/13/2007

28. Clinical note by MD, dated 3/5/2007
29. Notice of assignment by, dated 12/20/2007
30. Impairment dispute dated 10/25/2007
31. Report of medical evaluation dated 11/7/2007
32. Clinical note by MD, dated 6/25/2007
33. Clinical note dated 6/25/2007
34. Questionnaire dated 6/25/2007
35. Operative report by MD, dated 7/13/2006
36. Patient consultation by DO, dated 5/3/2006
37. Recheck note by DO, dated 5/12/2006 and 6/7/2006
38. Clinical note dated 1/2/2008
39. Report of medical evaluation dated 3/13/2007
40. Evaluation of permanent impairment by MD, dated 3/13/2007
41. Clinical note dated 2/28/2007
42. MRI of the right shoulder by MD, dated 2/28/2007
43. Clinical note by MD, dated 6/19/2006 3/15/2007, multiple dates
44. Workers compensation dated 8/15/2007
45. Injury information dated 4/13/2006
46. Clinical note dated 10/26/2007 to 12/7/2007, multiple dates
47. Shoulder note dated 10/26/2007
48. Clinical note dated 10/2/2007 to 10/23/2007, multiple dates
49. Shoulder note dated 10/2/2007
50. Cervical note dated 10/2/2007
51. Clinical note dated 4/13/2006
52. Request for a benefit dated 12/20/2007
53. Clinical note by DC, dated 1/2/2008
54. Patient information dated 11/19/2007
55. Examination report dated 11/19/2007
56. The ODG Guidelines were not provided

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This injured employee is a xx year-old male who was diagnosed with articular cartilage disorder of the shoulder region, intervertebral cervical disc disorder with myelopathy of the cervical region, and non-allopathic lesion of cervical region. This case is under review to determine whether the requested magnetic resonance imaging is medically necessary for this injured employee.

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

On xx/xx/xx the injured employee sustained an industrial injury resulting in shoulder pain. Following a failure of conservative treatment to bring about a resolution of his condition, the injured employee underwent subacromial decompression with acromioplasty and rotator cuff repair surgery on 7/13/2006. The injured employee underwent a course of postsurgical rehabilitation. A repeat shoulder MRI dated 2/28/2007 revealed evidence of probable small recurrent right rotator cuff tear. The determination was that the injured employee was not a candidate for additional surgical intervention. On 3/13/2007 the injured employee underwent an evaluation of permanent impairment by Dr., M.D. At the time this evaluation the injured employee had achieved complaints of right shoulder pain. An examination revealed that cervical rotation to the right caused some right-sided neck pain radiating to the injured employee's upper trapezius. Orthopedic testing was negative for radicular symptoms. Right shoulder ranges of motion findings were significantly reduced. The determination was that the injured employee had achieved maximum medical improvement with a whole person impairment rating of 13%. On 6/25/2007 the injured employee underwent a designated doctor examination with Dr., M.D. At the time of the evaluation the injured employee complained of "right shoulder pain, weakness, decreased range of motion, swelling, coolness, and problems sleeping secondary to shoulder pain." The injured employee was diagnosed with massive right rotator cuff tear, recurrent right rotator cuff tear, chronic regional pain syndrome type I of the right upper extremity, cervical radiculopathy, status post right rotator cuff tendon repair with subacromial decompression dated 7/13/2006, and depression. The injured employee was determined to be at maximum medical improvement. On 8/15/2007 the injured employee changed treating doctors and presented to the office of Dr., DC, complaining of right shoulder pain. On 10/2/2007 the injured employee began a course of six physical therapy sessions. On 11/29/2007 the provider submitted a request for a cervical MRI. This was denied by peer review and upheld on reconsideration.

The medical necessity for the requested cervical MRI was not established. The evaluation of permanent impairment report dated 3/13/2007 revealed no findings suggesting significant cervical involvement. The only cervical finding was that "cervical rotation to the right caused some right-sided neck pain radiating to his upper trapezius. However, Spurling's is negative for radicular symptoms down the right arm." All the remaining findings were specific to the injured employee's shoulder. The designated doctor's examination dated 6/25/2007 had the

following comment "despite the examinee being at MMI, it is this clinician's opinion that the examinee requires the following items in order to continue to receive medical treatment:

1. Anesthesiology consultation for right cervical Stelly sympathetic ganglion blockade
2. MRI of the cervical spine
3. A second opinion via an orthopedic surgeon with a fellowship training and upper extremity to evaluate the right shoulder"

This recommendation for an MRI of the cervical spine is curious given the absence of any significant cervical clinical findings. The evaluator noted that the injured employee had a diagnosis of cervical radiculopathy. However, there were no clinical findings to support this diagnosis. Dr. submitted a letter requesting that the MMI date be rescinded. When the injured employee presented to the office of Dr. on 8/15/2007 the injured employee only noted in injury to his right shoulder. An examination was performed that revealed significant shoulder findings. A cervical examination was performed that revealed a reduction in cervical ranges of motion findings. Reflex testing was normal and there is no evidence of any true dermatomal radicular complaints. In fact, the provider circled all five dermatomes with no specificity. Cervical compression test was noted to be positive on the right but was no evidence of radicular components. A re-examination was performed on 10/26/2007. At that time the only body part examined was the shoulder. There was no cervical evaluation performed at that time. This may indicated the injured employee did not have the cervical complaints at that time or that this evaluation was not supplied submitted documentation.

The Official Disability Guidelines for the neck give\ the following recommendations with respect to cervical MRI:

"Indications for imaging -- MRI (magnetic resonance imaging):

- Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present
- Neck pain with radiculopathy if severe or progressive neurologic deficit
- Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present
- Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present
- Chronic neck pain, radiographs show bone or disc margin destruction
- Suspected cervical spine trauma, neck pain, clinical findings suggest suggest ligamentous injury, radiographs and/or CT "normal"
- Known cervical spine trauma: equivocal or positive plain films with neurological deficit."

The documentation provided fails to support that this injured employee fulfills any of these indications. Based on the absence of any clinical findings supportive of radicular component, the medical necessity for the requested cervical MRI was not established. Therefore, the previous denial is upheld.

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

X 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)