

P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

DATE OF REVIEW: March 17, 2008

IRO CASE #:

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

This case was reviewed by a Pain Management Doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder MRI with arthrogram

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o July 5, 2007 operative report of Dr.
- o May 27, 2007 through February 8, 2008 physician reports of Dr.
- o December 3, 2007 through February 20, 2008 case management notes, source unclear
- o February 4, 2008 utilization review denial of reconsideration letter for right shoulder MRI with arthrogram
- o February 21, 2008 utilization review denial of repeat MRI with arthrogram right shoulder, injection
- o List of records (date, who from, description)
- o February 25, 2008 request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and previous physician reviews, the patient is an employee who sustained an industrial injury to the right shoulder when pulling a pipe wrench. MRI of May 4, 2007 showed a full-thickness tear of the supraspinatus tendon without retraction. The patient is status post right shoulder surgery of excision distal clavicle, acromioplasty, and rotator cuff repair on July 5, 2007 and is followed orthopedically by Dr.

Per a progress report of July 20, 2007, the patient was authorized to proceed with physical therapy through August 17, 2008. On examination, his wound is benign, he moves his fingers well, he can perform pendulum exercises without difficulty and he can move his arm to a little over 90 degrees before pain interferes with further motion. On August 3, 2007 right shoulder flexion was to 120 degrees.

Per a progress report of September 21, 2007 the patient demonstrates right shoulder flexion of 155 degrees and abduction of 144 degrees. He will continue with physical therapy and work limitations. On November 2, 2008 and November 30, 2008 right shoulder flexion is demonstrated to 160 degrees and abduction to 155 degrees. He continues to make gradual improvement.

Case management notes of December 3, 2007 and December 31, 2007 state the patient has been provided approximately 41

sessions of physical therapy. Return to work is planned for December 14, 2007. He is also awaiting surgery on his left wrist for a fusion. He has 160 degrees of right shoulder flexion and 155 degrees of abduction.

Per a progress report of December 14, 2007 the patient has completed formal physical therapy and has been transitioned to a home exercise program. Right shoulder flexion is to 160 degrees and abduction is to 155 degrees.

On January 25, 2008 the patient reported to Dr. that he feels he is losing ground and he has discontinued his home exercises. His range of motion is about the same (160/155). Recommendation is for a repeat MRI to monitor his rotator cuff healing.

Request for a repeat right shoulder MRI with arthrogram was denied on February 4, 2008 with rationale that the proposed treatment failed to meet the medical necessity guidelines primarily due lack of objective clinical findings in the medical records to justify the requested services/procedure. A single clinical note of January 21, 2008 was submitted. There was no documentation of the post-operative course of treatment. The patient subjectively indicates he is losing ground, but examination findings reflected the patient's range of motion to be about the same. There was an indication of continued weakness, but it was not graded.

Per a progress report dated February 8, 2008 the patient is seen in follow-up. His last visit was January 25, 2008. He feels he is losing ground. He is no longer doing well with his home exercises. It was recommended at that time that he have a repeat MRI scan. A repeat MRI has not yet been cleared. The patient's range of motion is about the same on examination. He continues to have weakness. He demonstrates flexion to 160 degrees and abduction to 155 degrees.

Request for reconsideration of denial of repeat right shoulder MRI was not certified in review on February 19, 2008 with rationale that the medical records failed to substantiate a medical necessity for the request. While the patient subjectively indicates he is losing ground, examination findings reflect his range of motion to be about the same. Continued weakness is reported, but not graded.

Request for IRO was dated February 25, 2008. No additional progress reports since the report of February 8, 2008 are available for review.

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

According to the Official Disability Guidelines, MRI and arthrography are performed on the shoulder primarily to visualize tears. Ultrasonography and magnetic resonance imaging have comparable high accuracy for identifying biceps pathologies and rotator cuff tears, and clinical tests have modest accuracy in both disorders. MRI is the most useful technique for evaluation of shoulder pain due to subacromial impingement and rotator cuff disease and can be used to diagnose bursal inflammatory change, structural causes of impingement and secondary tendinopathy, and partial- and full-thickness rotator cuff tears. Indications for magnetic resonance imaging of the shoulder are: Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs and/or subacute shoulder pain, suspect instability/labral tear. The medical records fail to document suspicion of a tear or impingement. The patient has chronic pain without documentation or suspicion of instability or labral tear. The medical records note good response to formal therapy and unchanged range of motion since December 3, 2007. The medical records fail to document objective physical examination findings of weakness or the results of plain films. Overall, there is not a medical necessity for magnetic resonance imaging substantiated in the medical records. Therefore, my determination is to uphold the prior non-certifications of the request for repeat right shoulder MRI.

The IRO's decision is consistent with the following guidelines:

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

Official Disability guidelines (2008):

Recommended as indicated below. Magnetic resonance imaging (MRI) and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific. Magnetic resonance imaging may be the preferred investigation because of its better demonstration of soft tissue anatomy. (Banchard, 1999) Subtle tears that are full thickness are best imaged by MR arthrography, whereas larger tears and partial-thickness tears are best defined by MRI, or possibly arthrography, performed with admixed gadolinium, which if negative, is followed by MRI. (Oh, 1999) The results of a recent review suggest that clinical examination by specialists can rule out the presence of a rotator cuff tear, and that either MRI or ultrasound could equally be used for detection of full-thickness rotator cuff tears. (Dinnes, 2003) Shoulder arthrography is still the imaging "gold standard" as it applies to full-thickness rotator cuff tears, with over 99% accuracy, but this technique is difficult to learn, so it is not always recommended. Magnetic resonance of the shoulder and specifically of the rotator cuff is most commonly used, where many manifestations of a normal and an abnormal cuff can be demonstrated. The question we need to ask is: Do we need all this information? If only full-thickness cuff tears require an operative procedure and all other abnormalities of the soft tissues require arthroscopy, then would shoulder arthrography suffice? (Newberg, 2000) Ultrasonography and magnetic resonance imaging have comparable high accuracy for identifying biceps pathologies and rotator cuff tears, and clinical tests have modest accuracy in both disorders. The choice of which imaging test to perform should be based on the patient's clinical information, cost, and imaging experience of the radiology department. (Ardic, 2006) MRI is the most useful technique for evaluation of shoulder pain due to subacromial impingement and rotator cuff disease and can be used to diagnose bursal inflammatory change, structural causes of impingement and secondary tendinopathy, and partial- and full-thickness rotator cuff tears. However, The overall prevalence of tears of the rotator cuff on MRI is 34% among symptom-free patients of all age groups, being 15% for full-thickness tears and 20% for partial-thickness tears. The results of this study support the use of MRI of the shoulder before injection both to confirm the diagnosis and to triage affected patients to those likely to benefit (those without a cuff tear) and those not likely to benefit (those with a cuff tear). (Hambly, 2007) The preferred imaging modality for patients with suspected rotator cuff disorders is MRI. However, ultrasonography may emerge as a cost-effective alternative to MRI. (Burbank, 2008)

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.