



---

Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax:  
877-738-4395

## **Notice of Independent Review Decision**

**DATE OF REVIEW:** 11/30/11

**IRO CASE #:**

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

Outpatient MRI of the right shoulder

**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.

Outpatient MRI of the right shoulder - Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

A Workman's Comp Verification Form from The Center dated 06/16/11  
City of Work Related Physical Activity Status Reports dated 07/09/11, 09/03/11, 09/17/11, 09/30/11, 10/14/11, and 10/29/11 from Dr.  
X-rays of the right shoulder dated 07/09/11 and interpreted by M.D.  
Evaluations at The Center with an unknown physician (the signature was illegible, presumably M.D.) dated 07/09/11, 09/03/11, 09/17/11, 09/30/11, 10/14/11, and 10/29/11  
A prescription for Naprelan dated 07/09/11 from Dr.  
DWC-73 forms signed by Dr. on 07/09/11, 09/03/11, 09/17/11, 09/30/11, 10/14/11, and 10/29/11  
A referral from Dr. for a physical therapy evaluation dated 07/29/11  
An initial physical therapy evaluation dated 08/01/11 with P.T.  
Notices of Intent to Issue an Adverse Determination from dated 08/08/11, 10/07/11, and 10/20/11  
Physical therapy reevaluations dated 08/31/11 and 09/01/11 from Therapist  
A request from Imaging dated 10/04/11 addressed to  
A Notice of Utilization Review Findings from M.D. with dated 10/10/11  
Another Notice of Utilization Review Findings from D.O. with dated 10/21/11  
An EES-14 dated 11/07/11  
The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

### **PATIENT CLINICAL HISTORY**

X-rays of the right shoulder on 07/09/11 were negative. On 07/09/11, Dr. diagnosed the patient with a right shoulder sprain/strain. The patient attended therapy from 08/09/11 through 08/31/11 for a total of 11 sessions with Therapist, according to the 08/31/11 evaluation. On 09/03/11, Dr. performed a subdeltoid bursal injection. On 09/17/11, the patient stated his shoulder was feeling better and he rated his pain at 2/10. Over-the-counter Ibuprofen was recommended. On 09/30/11, the patient informed Dr. he had finished physical therapy and he still had pain rated at 5/10 that increased with overhead reaching. Anaprox was prescribed and an MRI was recommended. On 10/10/11, Dr. on behalf of provided a Notice of Utilization Review Findings, non-authorizing the requested outpatient MRI of the right shoulder. Dr. reevaluated the patient on 10/14/11 and again noted the patient had not improved with physical therapy. His pain remained rated at 5/10. The diagnosis was a right shoulder strain with possible impingement. An MRI was again recommended. On 10/21/11, Dr., also on behalf of provided another Notice of Utilization Review Findings, non-authorizing the outpatient MRI of the right shoulder. Dr. noted 10/29/11 that the MRI was not authorized on appeal. It was noted the right shoulder had full range of motion. The remainder of the note was illegible.

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

Based on the documentation provided, this patient has pain in the right shoulder and has not responded as expected to the initial physical therapy provided to him. Dr. believes that there is impingement, but the physical examination has been very vague. On his examinations, Dr. essentially continues to circle under upper extremities, shoulder, range of motion, tender, NV intact, but there is very little additional objective information included. There is one note that states "increased pain with abduction and internal rotation." There is no mention of impingement signs or any other type of specific testing for impingement or rotator cuff problems. The ODG indicates the necessity for shoulder MRI for an acute shoulder trauma, include suspected rotator cuff tear/impingement, over age 40, and normal plain radiographs or for subacute pain or a suspicion of instability/labral tear. This patient is. The note of 10/29/11 from Dr. indicates the patient had full range of motion. As noted previously, there is no objective testing or documentation of instability or impingement. Therefore, the requested outpatient MRI of the right shoulder is not appropriate and the previous adverse determinations should be 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 AND KNOWLEDGE BASE
- 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)**