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Notice of Independent Review Decision

**DATE OF REVIEW:** MARCH 24, 2011

**IRO CASE #:**

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

Repeat MRI of left shoulder

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

This physician is a Board Certified Orthopedic Surgeon with over 40 years of experience.

**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**

On January 27, 2011 MD completed the Examination Form indicates positive for distress, positive for spine tilt, muscle strength left hand grip was rated 3/5. Left shoulder flexion was 90, extension was 30, abduction was 180, adduction was 40, external rotation was 45, and internal rotation was 45. Examination Form state that based upon the available information, to a reasonable degree for medical certainty, there is probably causal relationship between the current complaint and the reported work-related injury. Diagnosis given was status post left rotator cuff repair, subacromial decompression.

On January 27, 2011 Texas Workers' Compensation work Status Report was completed by MD. The report allowed the claimant to return to work as of January 27, 2011 with restrictions.

On February 22, 2011 a follow up Workman's' Comp Visit occurred with, M.D. the chief complaint for this visit was chronic left shoulder pain rated at 6/10 on the Verbal Analog Scale complicated by: stiffness, sharp pain, on and off pain, radiating pain to the left upper extremity, and numbness/tingling in the left hand. The report references "treatment to date" with none of the records received for this review reflecting dates 12/27/2006-2/16/2007. The examination performed during this visit reflects positive for "in distress", "minor's sign", "spine tilt". Left shoulder testing shows: flexion 90, extension 30, abduction 90, adduction 40, external rotation 45, internal rotation 45. Apley's was positive on the left. Speed's test was positive on the left. Diagnosis is 1) displacement of Cervical IVD w/o myelopathy C3-4, C4-5, C6-7; 2) Lumbar IVD w/o myelopathy at L4-5; 3) S/P rotator cuff repair, subacromial decompression.

On February 22, 2011, M.D. performed a utilization review on the claimant. Rationale: On 7/7/09, a MRI of the left shoulder post arthrogram showed flat or type 1 acromial remnant with no significant downsloping, diffuse thickening of the common rotator cuff tendon with a prominent tear in the distal supraspinatus component, possible adhesive capsulitis. EMG dated 10/21/07 showed no evidence of peripheral neuropathy. In addition, there is no objective documentations provided to confirm whether the claimant has indeed failed in the conservative management. This shall include the use of physical therapy, pain medications, and exercises. Therefore, this request is not substantiated at this time.

On February 28, 2011, M.D. performed a utilization review on the claimant. Rationale: There is no indication failure of the claimant to respond to other conservative measures such as oral pharmacotherapy and physical therapy.

## **PATIENT CLINICAL HISTORY:**

The claimant was injured when a non-lethal electrocution while cleaning a coffee machine. The claimant has undergone a left rotator cuff repair, subacromial decompression, and manipulation under anesthesia on 2/16/07. .

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

The previous decisions are overturned. The last shoulder MRI was performed in 09' and based on the clinical examination the claimant exhibits chronic left shoulder pain, limited range of motion, Apley's was positive on the left, and Speed's test was positive on the left. Based on the claimant's clinical exams MRI of the left shoulder is indicated.

### **PER ODG**

#### Magnetic resonance imaging (MRI)

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](#)) Primary care physicians are making a significant amount of inappropriate referrals for CT and MRI, according to new research published in the *Journal of the American College of Radiology*. There were high rates of inappropriate examinations for shoulder MRIs (37%), shoulder MRI in patients with no histories of trauma and documented osteoarthritis on plain-film radiography. ([Lehnert, 2010](#)) See also [MR arthrogram](#).

#### **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
- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. ([Mays, 2008](#))

**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)