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Notice of Independent Review Decision

DATE: May 17, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI Any Joint of Upper Extremity without Contrast (Right Shoulder)

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

The reviewer is certified by the American Board of Orthopaedic Surgery 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

07/11/03: Cervical Spine MRI report iwith Open MRI
07/22/03: Right Shoulder MRI report with Open MRI
11/10/03: Office Visit 05/23/08, 07/23/08, 09/24/08, 10/22/08, 04/21/09, 10/16/09,
04/14/10, 10/12/10: Followup Visit
10/25/11: Periodic Outcome Evaluation
02/13/13: Office Visit
03/14/13: UR performed
04/12/13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who injured her right shoulder and neck when she slipped on a wet floor hitting her head and shoulder while working on xx/xx/xx.

07/11/03: Cervical Spine MRI report. IMPRESSION: Small right paracentral disc protrusion at C5-C6 without visible neural impingement. Otherwise, unremarkable MRI scan of the cervical spine.

07/22/03: Right shoulder MRI report. IMPRESSION: There is a small amount of fluid in the right subacromial/subdeltoid bursae consistent with bursitis. There is mild degenerative capsular hypertrophy and spurring of the acromioclavicular joint. There is no MRI evidence of impingement. There is no rotator cuff tear.

05/23/08: The claimant was evaluated for chronic intractable neck pain. On exam, she had restricted motion of the cervical spine. She had symmetric upper and lower extremity reflexes without weakness. She was given a two-month supply of methadone for chronic pain. She was referred for a chronic pain program.

09/24/08: The claimant was evaluated. It was noted that she had completely weaned off the methadone. She was taking Tylenol for pain control. She complained of increased neck stiffness and tingling in her right upper extremity. She was started on Cymbalta.

04/14/10: The claimant was evaluated. It was noted that she was off Cymbalta as the insurance company was not paying for it. She continued to take Lyrica. On exam, she had symmetric upper extremity reflexes with no weakness. She was given prescriptions for Lyrica and Norco.

02/13/13: The claimant was evaluated for complaints of right-sided neck pain described as stabbing and burning in nature with stabbing pain in the right parascapular area. Her pain was localized to the right cervical spine and right shoulder as well as the right parascapular area radiating to the proximal posterior arm. It was noted that she had an opinion from a surgeon that she was not a surgical candidate for her cervical spine. On physical exam, her cervical spine was tilted to the right. Levator scapulae, trapezius, scalenus muscles were tender on the right. Cervical range of motion was painful and restricted with range of motion. Hoffman's sign was absent. Spurling's test was negative on the right and negative on the left. Waddell's test showed non-specific tenderness, simulation/axial loading. Upper extremity strength was symmetrically present in all upper extremity muscle groups. Upper extremity reflexes were present and normal. Light touch was normal for all cervical dermatomes. Cervical AP and lateral view x-rays performed in the office demonstrated moderate spondylosis in the mid-lower cervical spine but no significant disc space narrowing. ASSESSMENT: with work-related injury in xxxx resulting in chronic right-sided neck and periscapular pain without neurologic injury. Chronic pain managed with OTC NSAIDs. stated that he wondered if her chronic pain was a result of a right shoulder problem as a result of her injury in xxxx. He ordered an MRI of the right shoulder to evaluate if she had a right rotator cuff injury.

03/14/13: UR performed. Non-Authorize right shoulder MRI given lack of clinical information. There is no examination of the right shoulder and no mention of review of the old MRI to make a comparison of current symptoms/physical findings to support any suspected pathology requiring further imaging.

04/12/13: UR performed. At the present time, for the described medical situation, ODG would not support this specific request to be of medical necessity. This reference would currently not support this request to be one of medical necessity as there are a lack of documented physical examination findings to support a medical necessity for the requested diagnostic study. As such presently, in this particular case, medical necessity for this request is not supported per criteria set for by the above noted reference.

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

The previous adverse decisions are upheld. The documentation submitted for review indicates that the claimant's injury occurred in xxxx. She had an MRI in July of 2003, which showed no acute injury. There is no documentation that the claimant meets the ODG indications of a significant change in symptoms and/or findings suggestive of significant pathology. There is no documentation of a recent shoulder examination that would suggest acute trauma. Therefore, the request for MRI Any Joint of Upper Extremity without Contrast (Right Shoulder) is not medically necessary and is non certified.

ODG:

Magnetic resonance imaging (MRI)	<u>Indications for imaging -- Magnetic resonance imaging (MRI):</u> <ul style="list-style-type: none">- 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)
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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)**