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Notice of Independent Review Decision

**August 5, 2014**

**IRO CASE #:**

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

Magnetic resonance imaging (MRI) without and with contrast left shoulder

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

Certified by the American Board of Orthopaedic Surgery  
Recertified by the American Board of Orthopaedic Surgery, 2011  
Orthopaedic Sports Medicine Subspecialty CAQ, ABOS, 2011

**REVIEW OUTCOME:**

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

**ODG criteria have been utilized for the denials.**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who was getting on the shuttle bus on xx/xx/xx. The door closed on her, allegedly causing injuries to her right shoulder, back and right hip.

From June 3, 2008 through July 14, 2008, the patient attended PT.

On June 17, 2008, magnetic resonance imaging (MRI) of the lumbar spine showed mild and minimal diffuse annular disc bulges at L2-L3 and L4-L5, respectively, mild multiple level lumbar anterior spondylosis and straightening of the lumbar lordosis.

On June 23, 2008an orthopedic surgeon, evaluated the patient for bilateral shoulder pain, right worse than left. Examination revealed overall good range of

motion (ROM) of the right shoulder. Hawkins' and Neer tests were positive. There was mild tenderness to palpation about the proximal shoulder. There was not much tenderness to palpation of the left shoulder. X-rays of the right shoulder were normal. X-rays of the left shoulder revealed a faint haziness at the proximal humerus that appeared to be early developing heterotopic ossification. diagnosed bilateral shoulder contusions and sprains, prescribed Lortab and Flexeril and recommended physical therapy (PT).

On July 7, 2008, refilled Lortab and Flexeril and also switched the patient to Celebrex from the Mobic as she had a little bit of stomach irritation.

On August 4, 2008, administered injection of lidocaine and dexamethasone into the right shoulder. The patient

On August 7, 2008, the patient underwent a functional capacity evaluation (FCE). The patient performed at a light physical demand level (PDL) versus medium PDL required by her job.

On August 10, 2008, MRI of the right shoulder showed supraspinatus and infraspinatus tendinosis, mild acromioclavicular (AC) joint degenerative change without significant undersurface spurring and small fluid collection in the subacromial-subdeltoid bursa.

On August 18, 2008, noted the injection had helped somewhat, and PT was helping greatly. She still had a little more pain in the right shoulder than in the left, but overall was improving. recommended completion of therapy followed by a work-conditioning program (WCP).

From September 15, 2008 through November 20, 2008, evaluated the claimant. recommended therapy, work conditioning and surgery.

On November 21, 2008, performed right shoulder arthroscopy with acromioplasty, debridement of the rotator cuff and release of adhesions (scarred into the biceps tendon).

On December 4, 2008, the patient reported that her postoperative pain was slowly improving. She had been having a fair amount of difficulty with the treatments. The patient still had a fair amount of guarding at the shoulder. recommended discontinuing the sling. The patient would like to continue with her PT. She was to remain off work at that time.

On December 15, 2008, performed right-sided L5 and S1 transforaminal epidural steroid injection (ESI). Postoperative diagnosis was herniated nucleus pulposus (HNP) at L5-S1.

**2009:** On January 5, 2009, noted the patient was doing better than she was before the operation. She still had some pain and weakness in the shoulder. recommended continuing PT and felt that the patient might need WCP.

On January 23, 2009, saw the patient for back pain and right leg symptoms. diagnosed mechanical back pain and right trochanteric bursitis. He recommended trochanteric injection, but the patient was not interested. recommended continuing therapy.

On February 16, 2009, noted good ROM. However, the patient lacked a little bit of forward flexion and had a very mildly positive Neer forward flexion impingement sign. There was slight weakness with supraspinatus isolation. felt the patient could return to unrestricted activity following another week of work conditioning.

On July 9, 2009, the patient reported that right shoulder was doing much better. She primarily complained of pain in the hip region. She reported that she got struck there at the time of her original injury. X-rays of the right hip were unremarkable. diagnosed bilateral shoulder rotator cuff strains and greater trochanteric bursitis. He administered injection of lidocaine and dexamethasone to greater trochanteric bursa.

On September 10, 2009, noted that injection into the trochanteric bursa had not provided any relief. The patient reported burning sensations in her hip. prescribed Norco and ordered MRI of the right hip.

On November 23, 2009, MRI of the right hip was negative. There was a 2.3 cm hemorrhagic left ovarian cyst and smaller physiologic, follicular right ovarian cysts.

On November 30, 2009, prescribed Norco and Soma.

On December 22, 2009, the patient reported 80% relief of her pain lasting for seven days and then the pain gradually returned. opined the patient was a good candidate for a medial branch radiofrequency neurotomy on the right at L3, L4 and L5.

On March 1, 2010, performed a post-designated doctor required medical evaluation (PDDRME). He assessed maximum medical improvement (MMI) with 13% whole person impairment (WPI) rating. Following treatment history was noted: *On February 5, 2008, MRI of the right shoulder showed globular abnormal increased signal intensity and mild thickening involving the supraspinatus, infraspinatus and subscapularis tendons most consistent with the tendinopathy vs. a partial tear. There was trace amount of fluid within the subacromial-subdeltoid bursa likely secondary to mild bursitis. There was mild subchondral cyst formation within the lateral portion of the humeral head posteriorly. There was mild bone marrow edema involving the lateral portion of the humeral head near the greater tuberosity as well as the superior portion of the glenoid, this finding was nonspecific but might be secondary to a mild stress reaction. There was mild AC joint osteoarthritis.*

*On June 10, 2008, MRI of the right shoulder showed supraspinatus and infraspinatus tendinosis. There was mild AC joint degenerative changes, without*

*significant undersurface spurring. There was small fluid collection in subacromial-subdeltoid bursa.*

*On September 17, 2008, performed a designated doctor evaluation (DDE) and opined that the patient had not reached maximum medical improvement (MMI) and was estimated date of MMI was November 17, 2008. The patient was to continue work conditioning and return to full duty at the completion of that.*

On March 11, 2010, noted increased left shoulder pain and ongoing right hip pain. injected the left subacromial space with dexamethasone and lidocaine and refilled Norco.

On April 1, 2010, the patient reported no relief in pain following the left shoulder injection. refilled Flexeril and Narco and ordered MRI of the left shoulder.

On April 13, 2010, MRI of the left shoulder revealed marked tendinopathy/tendinosis involving the distal supraspinatus tendon, mild to moderate degenerative osteoarthritis of the AC joint and mild degenerative subcortical fibrocystic change involving the superior glenoid.

On April 19, 2010, refilled Norco and recommended arthroscopy acromioplasty.

On June 18, 2010, performed superior labral anterior-posterior (SLAP) repair, debridement of the partial rotator cuff tear and arthroscopic acromioplasty of the left shoulder.

On June 28, 2010, prescribed Percocet, continued immobilizer but recommended passive ROM.

On September 23, 2010, noted diffuse tenderness and positive Neer and Hawkins's test in the left shoulder. The passive external rotation was 20 degrees and flexion was 135 degrees. recommended continuing ROM and strengthening.

On October 21, 2010, noted pain in the left shoulder that was not as before but was getting there. The patient reported weakness and felt that it was progressing. refilled Lortab,

**2011:** On February 25, 2011, letter of medical necessity was submitted for transcutaneous electrical nerve stimulation (TENS) unit.

**2012 – 2013:** No records are available.

**2014:** On January 23, 2014, performed RME and opined that the appropriateness of care would most likely include following up and surgery on the left shoulder.

On May 29, 2014, reported left shoulder pain. noted that the patient was status post left shoulder SLAP repair, rotator cuff debridement and acromioplasty. She had been doing well but had onset of shoulder pain that progressively worsened and had limited ROM. A repeat MRI was obtained at that time and revealed that

the SLAP repair was intact but there was progression of partial rotator cuff tear possibly secondary to overuse. The patient complained of numbness in her hand and numbness and tingling that radiated down her arm. She reported that she had anterior shoulder pain as well as weakness and reaching above the shoulder level exacerbated her symptoms. Examination of the left shoulder revealed no tenderness, full ROM, reasonable strength, no joint instability on provocative testing and positive Neer's, Hawkin's, and Speed's tests. X-rays of the left shoulder/humerus showed evidence of a prior acromioplasty but were otherwise normal. diagnosed left shoulder partial rotator cuff tear. He ordered MRI with gadolinium arthrogram. The patient was advised to retrieve the EMG results that she recently underwent for review.

Per utilization review dated June 26, 2014, the request for MRI with and without contrast of the left shoulder was denied with the following rationale: *“This individual reported an occupational incident on xx/xx/xx. In 2010, the individual underwent left shoulder SLAP repair and rotator cuff debridement and acromioplasty. Applicable clinical practice guidelines support MRI and MRI with arthrogram to help in the diagnosis of reasonably suspected rotator cuff tear and impingement in individuals over the age of 41 radiographs are normal and MRI to help in the diagnosis of reasonably suspected labral tears in the shoulder. The available information on this individual says only that she underwent left shoulder SLAP repair and rotator cuff debridement with acromioplasty in 2010; with no report of current results the medical necessity for obtaining left shoulder MRI with and without arthrogram is not clearly demonstrated.”*

Per RME summary dated July 8, 2014, following information was noted: *On January 29, 2009, the patient underwent an FCE, in which she tested in the Medium-Heavy PDL, which met her job requirement. However, due to the pain and discomfort associated with performing the tasks, the therapist recommended WCP prior to return to work.*

*On March 2, 2009: evaluated the patient for pain in the right hip, shoulders, upper back and low back, with associated numbness and tingling into both feet. noted pain and muscle spasms in the cervical, thoracic and lumbar regions. He performed chiropractic modalities, including EMS with ice, traction decompression and myofascial release.*

*On October 30, 2009; performed a designated Doctor evaluation and opined that the patient had not reached MMI and would benefit from epidural steroid injections (ESI).*

*On February 21, 2011, noted diffuse tenderness of the left shoulder, positive Neer's and Hawkin's. administered injection to the left shoulder, refilled Norco and ordered arthrogram due to the persistent complaints.*

*On May 13, 2011, the patient underwent an MR arthrogram and MRI of the left shoulder that revealed high-grade 6 x 6 mm partial articular surface tear of the distal supraspinatus tendon. However, the extent of the partial tear could be more*

*extensive given the heterogeneous thickened appearance of the superior cuff and retraction of the inferior tendon margin. The patient was unable to perform the ABER position to further define this area. The superior labral repair was intact.*

*On June 13, 2011, injection left shoulder with dexamethasone and lidocaine. He recommended surgical repair but the patient stated that she could not miss work. He refilled Norco.*

*On September 20, 2011, performed a peer review and opined that current medical was not reasonable or necessary and related to the original compensable injury. The complete rotator cuff tear most likely occurred from another injury.*

*On August 17, 2012, performed a peer review and rendered the following opinions: The original compensable injuries had resolved. The complete rotator cuff tear most likely occurred from another injury. Regarding the right shoulder, pre-existing, age related degenerative issues would include mild AC joint degenerative change as noted on MRI. Additional findings at the time of surgery were impingement syndrome and adhered proximal biceps tendon, which in all medical probability, were age related and not related to the compensable injury. In the left shoulder, the MRI findings of AC joint degenerative osteoarthritis and degenerative subcortical fibrocystic change involving the superior glenoid would be pre-existing and degenerative issues. Additional findings at the time of surgery were SLAP tear and a partial rotator cuff tear and post-operative MR arthrogram of the left shoulder revealed partial articular surface tear of the distal supraspinatus tendon; these conditions were also, in all medical probability, age related and not related to the compensable injury. In the lumbar spine, the diffuse annular disc bulges at L2-L3 and L4-L5 as well as multiple level lumbar anterior spondylosis noted on MRI would be pre-existing. Documentation did not support progress from current treatment. Treatment should have remained conservative in nature for the compensable injuries. Her failure to improve with conservative management was, in all medical probability, due to injuries superimposed on pre-existing degenerative changes. The patient's conditions had never fully improved, but her conditions had plateaued to the point where no further treatment was indicated for the compensable injuries. There was no indication for any type of surgery in the future for the compensable injury. Further treatment or diagnostic testing was not reasonable or medically necessary for the compensable injury. There was no need for pain management care. There was no indication for any psychological evaluation or treatment, additional PT, work hardening, work conditioning, or office visits. Norco was unnecessary. No further aggressive medical treatment was indicated. The patient should have been provided with a home exercise program (HEP) and should take over-the-counter (OTC) analgesics and/or anti-inflammatories as needed for symptoms.*

*Per reconsideration review dated July 8, 2014, the appeal for MRI of the left shoulder with and without contrast was denied with the following rationale: "This patient is status post rotator cuff debridement; acromioplasty and SLAP repair of the left shoulder on June 18, 2010. noted on May 29, 2014, the patient was doing well until 4-5 months ago and an onset of shoulder pain progressively worsened*

*with limited motion and weakness noted. The repeat MRI at that time noted the SLAP repair was intact but progression of a partial rotator cuff tear possibly due to overuse. noted the patient now reporting numbness of the hand with numbness and tingling radiating down the right arm and she has shoulder pain as well as weakness. Reaching above the shoulder exacerbated symptoms. The patient had a positive Hawkins and Neer's signs. It was noted that this request was previously non-certified; however, the rationale for non-certification was not available for review. According to ODG, repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The medical records provided did not document significant progressive deficits since the MRI 4-5 months ago that would support a repeat MRI within ODG recommendations. Therefore, the request is not certified."*

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

Per ODG, the MRA guidelines refer back to the MRI guidelines concerning criteria for use, as follows:

##### **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](#))

The criteria for ordering any MR study have not been met, per ODG. There is no suggestion in ODG that a MR study should supplant routine and typical conservative management vis-à-vis the acute onset of symptoms (aside from certain types of substantial trauma). The preauthorization denials appear to have been appropriately determined based on ODG criteria.

#### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**