

# US Decisions Inc.

An Independent Review Organization  
8760 A Research Blvd #512  
Austin, TX 78758  
Phone: (512) 782-4560  
Fax: (207) 470-1085  
Email: manager@us-decisions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Dec/16/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** MRI right shoulder with contrast, MRI cervical spine with contrast, MRI thoracic spine with contrast

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

**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 medical necessity exists for each health care service in dispute.** It is the opinion of this reviewer that the request for an MRI right shoulder with contrast, MRI cervical spine with contrast and MRI thoracic spine with contrast is not recommended as medically necessary.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
Chest x-ray dated 08/15/13  
Clinical note dated 07/07/08  
Clinical note dated 05/07/10  
Clinical note dated 06/04/10  
Clinical note dated 11/11/10  
Clinical note dated 08/09/11  
Clinical note dated 11/09/11  
Clinical note dated 02/07/12  
Clinical note dated 08/19/13  
Functional capacity evaluation dated 09/19/13  
Clinical note dated 10/21/13  
Clinical note dated 10/24/13  
Adverse determination dated 10/15/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female who reported an injury regarding her neck and shoulders. The clinical note dated 07/07/08 indicates the patient rating her pain as 6/10. Tenderness was noted upon palpation along with spasms throughout the cervical region. The clinical note dated 08/09/11 indicates the patient continuing with 4-9/10 pain in the neck and right shoulder. The note indicates the patient having undergone 2 arthroscopic surgeries at the right shoulder in 2003 & again in 2004. Upon exam, tenderness was noted in the paravertebral musculature throughout the cervical spine, bilaterally. Strength deficits were noted with flexion. Tenderness was noted upon palpation in the right shoulder. The clinical note dated 02/07/12 indicates the patient continuing with 3-9/10 pain in

the neck and right shoulder. The patient was able to demonstrate 60 degrees of cervical flexion and 40 degrees of extension along with 40 degrees of bilateral lateral rotation. Pain was elicited in all ranges. The patient was able to demonstrate 4/5 strength with cervical flexion. The clinical note dated 08/19/13 indicates the patient stating the initial injury occurred when she was removing a staple from a filter and felt a pop in her shoulder. Range of motion deficits continued throughout the cervical and right shoulder. The functional capacity evaluation dated 09/19/13 indicates the patient having undergone 4 epidural steroid injections in the cervical region. The note indicates the patient able to demonstrate a light physical demand level.

The clinical note dated 10/21/13 indicates the patient rating her pain as 6/10 at that time. The note indicates the patient utilizing Naproxen, Norco, and Lidoderm patches. The note indicates the patient having undergone an x-ray of the right shoulder; however, no results were submitted. The note further indicates the patient having undergone an MRI of the right shoulder; however, no imaging reports were provided. The clinical note dated 10/24/13 indicates the patient having undergone an MRI of the cervical spine which revealed osteophytes. The MRI of the right shoulder revealed mild intraligamentous degenerative changes.

The utilization review dated 10/15/13 resulted in a denial for an MRI of the cervical, thoracic, and right shoulder regions as no updated information had been provided indicating the clinical need for imaging studies.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The documentation submitted for review elaborates the patient having complaints of pain at the right shoulder and cervical region. An MRI would be indicated at the right shoulder provided the patient meets specific criteria to include the possibility of a labral or rotator cuff tear. No information was submitted regarding the patient's provocative testing indicating a labral tear or rotator cuff involvement. An MRI of the cervical spine would be indicated provided the patient meets specific criteria to include radiograph studies indicating significant findings. No radiograph studies were submitted for review. Given this, the request is not indicated. An MRI of the thoracic spine would be indicated provided the patient meets specific criteria to include findings indicating neurologic deficits associated with the thoracic region. No information was submitted regarding the patient's clinical information confirming any neurologic deficits associated with the thoracic spine. As such, it is the opinion of this reviewer that the request for an MRI right shoulder with contrast, MRI cervical spine with contrast and MRI thoracic spine with contrast is not recommended as medically necessary.

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

ACOEM-AMERICA 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)