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Notice of Independent Review Decision

DATE OF REVIEW: July 30, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder magnetic resonance imaging (MRI) without contrast.

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

M.D., 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)

I have determined that the requested left shoulder magnetic resonance imaging (MRI) without contrast is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with a history of left shoulder pain. The patient has been diagnosed with shoulder region disorder and internal derangement of the knee. The patient was evaluated on 5/12/14 for left shoulder symptoms. Physical examination on 5/12/14 revealed severe pain in the left shoulder acromioclavicular joint with positive impingement testing in the anterolateral acromion with rotator cuff signs. The patient was referred for a repeat magnetic resonance imaging (MRI) of the left shoulder. It was noted that the patient's previous MRI of the left shoulder was completed one year prior. A request has been submitted for left shoulder MRI without contrast.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the URA noted that repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The URA indicated that the patient had a previous MRI, and the clinical notes provided did not demonstrate any significant change in symptoms or findings suggestive of significant pathology, other than increasing subjective complaints. On appeal, the URA indicated that there is no documentation of significant changes in symptoms or findings of significant pathology in the patient such as shoulder laxity.

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

According to the Official Disability Guidelines (ODG), the indications for imaging of the shoulder include acute shoulder trauma with suspicion of a rotator cuff tear/impingement with normal plain radiographs or sub-acute shoulder pain with suspected instability or labral tearing. A repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Per the documentation provided for review, this patient was evaluated on 4/25/14 and 5/12/14 with complaints of persistent left shoulder symptoms. There was no documentation of a change in symptoms or physical examination findings. Therefore, the medical necessity for a repeat imaging study has not been established. All told, the requested left shoulder MRI without contrast is not medically indicated in this patient's case.

Therefore, I have determined the requested left shoulder MRI without contrast is not medically necessary for treatment of the patient's medical condition.

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 JUDGMENT, 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)**