

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

July/28/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

An MRI arthrogram of the left shoulder

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

Board Certified Orthopedic Surgeon

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury to his left shoulder when he felt a pinch in the left shoulder. The MRI of the left shoulder dated 01/08/14 revealed a previous acromioplasty at the left shoulder. Small glenohumeral joint effusion was identified with small subacromial subdeltoid bursitis. A mild intrasubstance signal within the distal supraspinatus and infraspinatus tendons was identified compatible with a grade 1 strain versus mild tendinosis. No rotator cuff tears were identified. The clinical note dated 01/10/14 indicates the patient continuing with complaints of left shoulder pain. There is an indication the patient has completed 6 physical therapy sessions to date. The note indicates the patient having previously undergone a surgical procedure. The surgical scar presented with tenderness at the anterior aspect of the shoulder. The patient did demonstrate decreased range of motion. The clinical note dated 01/21/14 indicates the patient rating the left shoulder pain as 4/10. Pain was elicited with overhead use. The note does indicate the patient rating the pain as 4/10. There is an indication the patient underwent x-rays of the left shoulder which revealed a type 2 acromion. The clinical note dated 02/10/14 indicates the patient having undergone a subacromial injection on 01/21/14 which provided the patient with 5 days of relief. However, the patient reported a return to baseline levels of pain. The clinical note dated 03/18/14 indicates the patient showing rotator cuff tendinopathy at the left shoulder. The patient had a positive impingement sign with significant reduction in elevation at the left shoulder. Weakness was also identified with abduction. The patient was able to demonstrate 130 degrees of forward elevation.

The utilization review dated 02/19/14 resulted in a denial for an MRI arthrogram as physical

examination findings did not demonstrate rotator cuff pathology at that time. The patient was able to demonstrate essentially full range of motion throughout the left shoulder. No positive orthopedic findings were identified indicating the necessity for an MRI arthrogram at that time.

The utilization review dated 03/26/14 resulted in a denial as no information had been submitted regarding any significant changes in the patient's symptomology at the left shoulder. No new development of significant pathology was available.

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

The request for an MRI arthrogram of the left shoulder is non-certified. The documentation indicates the patient complaining of left shoulder pain. The patient has been identified as having previously undergone an MRI of the left shoulder as recently as 01/08/14. The MRI revealed no significant pathology throughout the rotator cuff. The more recent clinical notes indicate the patient demonstrating 130 degrees of forward elevation. However, no other significant range of motion deficits were identified. There is an indication the patient has a positive impingement sign. However, no other provocative findings were made available indicating additional pathology. Given these findings, the request for a repeat imaging study to include an MRI arthrogram of the left shoulder is not indicated for this patient at this time. As such, it is the opinion of this reviewer that the request for an MRI arthrogram of the left shoulder is not recommended as medically necessary.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES