

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Feb/3/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI right shoulder without contrast

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Operative report 08/29/13

Clinical note 12/11/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury to his right shoulder. Procedure note dated 08/29/13 indicated the patient undergoing arthroscopic biceps tenodesis. Clinical note dated 12/11/13 indicated the patient complaining of moderate right shoulder pain. The patient stated that the pain occurred only on occasion. The patient described the pain as a deep, aching sensation that fluctuated. Lifting and lifting and moving the arm exacerbated the pain. Tenderness and weakness were noted. The patient utilized Flexeril, ibuprofen, Norco, Restoril, Ultracet, and Ultram for ongoing pain relief. Upon exam the patient demonstrated internal rotation to L3. The patient noted a popping sensation. The patient was recommended for MRI of the right shoulder. The utilization review dated 12/17/13 resulted in

a denial as no information was submitted indicating increased symptomology. Utilization review dated 12/26/13 resulted in a denial for repeat MRI as no documentation was submitted regarding any post-operative therapy or documented reason for a repeat MRI.

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

Clinical documentation indicates the patient complaining of right shoulder pain despite previous surgical intervention. Repeat MRI would be indicated provided that the patient meets specific criteria, including significant changes in the symptomology or significant pathology was noted by clinical exam. No information was submitted confirming significant changes in the patient's clinical presentation involving the symptomology or pathology. As such, it is the opinion of this reviewer that request for repeat MRI of the right 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