

# INDEPENDENT REVIEWERS OF TEXAS, INC.

2150 S. Central Expressway · Suite 200-264 · McKinney, Texas 75070

Office 214-533-2864 Fax 469-219-3349

e-mail: [independentreviewers@hotmail.com](mailto:independentreviewers@hotmail.com)

Notice of Independent Review Decision

**[Date notice sent to all parties]:**

**01/26/2015**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MRI right shoulder**

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

**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 of the health care services in dispute.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reported an injury to his right shoulder on xx/xx/xx when he was attempting to lift. The patient reported subsequent right shoulder injury. The patient described sharp and stabbing pain at the right shoulder. The patient rated the pain 8/10. Extending the arm exacerbated the pain level. Upon palpation, hypertonicity was identified throughout the right shoulder. Moderate tenderness and edema were revealed. The patient demonstrated 90 degrees of right shoulder flexion, 35 degrees of extension, 90 degrees of abduction, 20 degrees of adduction, 35 degrees of internal and external rotation. The patient had

a positive Apley's test. X-rays of the shoulder revealed no fractures or dislocations. A clinical note dated 11/03/14 indicated the patient continuing with right shoulder pain. The patient continued with 8/10 pain at the shoulder. A clinical note dated 12/09/14 indicated the patient undergoing physical therapy including active and passive modalities. A clinical note dated 01/06/15 indicated the patient recommended for MRI. The utilization review dated 12/01/14 and 12/30/14 resulted in denials as there was lack of objective findings confirming rotator cuff impingement involvement.

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

The patient complained of ongoing right shoulder pain. The patient initiated physical therapy to address right shoulder complaints. The MRI of the shoulder is indicated provided that the patient meets specific criteria, including significant findings resulting in possible rotator indicating possible rotator cuff tear or impingement and or suspected instability as result of a labral tear. The patient has range of motion deficits upon initial evaluation. However, it is unclear if the patient continues with range of motion deficits as no additional testing was submitted. No significant provocative tests were submitted confirming possible rotator cuff or labral involvement. Given the lack of objective data regarding significant findings at the right shoulder this request is not indicated. As such, it is the opinion of this reviewer that the request is not medically indicated at this time.

**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**

Magnetic resonance imaging (MRI)

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)