

P-IRO Inc.

An Independent Review Organization

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Case Number:

Date of Notice: 11/02/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Repeat MRI Left Shoulder

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)

Patient Clinical History (Summary)

The patient is a male who reported an injury to his left shoulder on XX/XX/XX. The clinical note dated XX/XX/XX indicates the patient reporting the initial injury occurred when he was lifting a heavy bag on XX/XX/XX. The patient reported immediate shoulder pain with subsequent difficulty maintaining his sleep hygiene. The rated the pain as 5/10. Fortified strength was identified with supraspinatus testing. The patient was able to demonstrate 160 degrees of passive elevation with 50 degrees of passive external rotation. There is an indication the patient had a positive impingement sign that time. X-rays revealed a well seated humeral head within the glenoid fossa. A type 2 acromion was identified. The MRI of the left surely shoulder dated xxxx revealed mild degenerative arthrosis identified at the acromioclavicular joint. The rotator cuff, biceps tendon, and labrum appeared intact. A type 1 acromion was revealed. The clinical note dated xxx indicates the provider reporting the previous MRI was of a poor quality. The adverse the utilization reviews dated xxx and xxxx resulted in denials as insufficient information had been submitted regarding the patient's clinical findings supporting an additional MRI.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The documentation indicates the patient complaining of ongoing left shoulder pain with associated range of motion deficits. A repeat MRI of the shoulder is indicated provided the patient meets specific criteria including significant changes identified with the patient's clinical findings or the development of new pathology was has been revealed. No information was submitted regarding any new or excusing any significant changes on the patient's symptoms. Additionally, no information was submitted regarding the patient's development of any new pathology. Furthermore, no information was submitted regarding the patient's completion any therapeutic interventions. Given these factors, the request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for an M repeat MRI of the left shoulder is not indicated 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 and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- 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 and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical Literature (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)