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DATE NOTICE SENT TO ALL PARTIES: Jun/21/2016

IRO CASE #:

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

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

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. This reviewer cannot recommend certification for the MRI right shoulder with contrast.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on XX/XX/XX while moving a box. The patient developed complaints of right shoulder pain and was assessed with impingement syndrome. Radiographs of the right shoulder from XX/XX/XX found no gross abnormality. The patient did have an MRI study of the right upper extremity including the right shoulder on XX/XX/X which noted an intact rotator cuff and some bursitis. There was an addendum completed by the radiologist indicating that an MR arthrogram would be needed in order to rule out a loose body or osteochondral defects. The patient was being followed by XX through XX/X/XX. The XX/XX/XX clinical report noted no significant changes in symptoms. The patient's physical exam noted tenderness in the right shoulder over the acromioclavicular border as well as the anterior glenohumeral joint. There were positive impingement signs noted with a painful arc of motion from 80 to 100 degrees' abduction. The patient did receive an injection at this evaluation. The MRI of the right shoulder with contrast was denied by utilization review on XX/XX/XX as the MRI study found no evidence of loose bodies and there was no indication that the prior study was inconclusive or was of poor quality. The request was again denied on XX/XX/XX as it was unclear how therapeutic management would be altered with an MR arthrogram showing evidence of loose bodies. Prior MRI studies were performed less than a month prior to the request. There was also no evidence of change in the patient's symptoms or condition that would warrant updated imaging.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has continued to demonstrate positive impingement signs with painful arc of motion on physical exam. The patient did undergo an injection on XX/XX/XX; however, it is unclear what the patient's response was to this injection. The addendum for the prior MRI study stated that in review of the findings with XX, MR arthrogram studies would be recommended to identify loose bodies or progressive changes in the proximal humerus.

As it is unclear what the response was to the patient's prior injection and there were no substantial changes on the patient's presentation or physical exam findings, repeat imaging studies to include MR arthrogram studies would not be supported as medically necessary.

The patient did not present with any other indications suggestive for labral path that would otherwise require contrasted studies. As such, this reviewer cannot recommend certification for the MRI right shoulder with contrast and the prior denials are upheld.

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

ACOEM-AMERICA 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 JUDGEMENT, 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)