Date notice sent to all parties: 3/20/2018
IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of an ultrasound of the left shoulder.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a Medical Doctor who is board certified in 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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of an ultrasound of the left shoulder.

PATIENT CLINICAL HISTORY [SUMMARY]:
This patient is a XX who sustained an industrial injury on XXXX. Injury occurred when XX and felt a strain to the left upper arm above the left elbow, and the pain continued when XX. A review of records documented initial conservative treatment to include NSAIDs, over-the-counter analgesics, heat, ice, rest, and physical therapy. XX continued to work full duty. The XXXX treating physician report cited continued left shoulder and elbow pain. XX reported that XX pain was grade 6/10 and intermittent. Pain was relieved by heat and ice. XX had been attending physical therapy since the date of injury but continued to have pain. Left elbow exam documented lateral epicondyle tenderness and full and pain free range of motion. Left shoulder exam documented greater tuberosity tenderness, negative orthopedic testing, 5/5 strength, and full range of motion. The diagnosis was documented as left shoulder rotator cuff syndrome and left elbow lateral epicondylitis. The treatment plan recommended an ultrasound of her left shoulder to assess her rotator cuff, continued physical therapy, and massage therapy for the left arm. The XXXX peer review report indicated that the request for an ultrasound of the left shoulder was not medically necessary. The rationale stated that the patient had full range of motion and strength about the affected shoulder and further conservative treatment was planned. There was no clear reason why the ultrasound was ordered when it did not appear that it would influence or alter

the treatment plan. The XXXX treating physician report cited persistent intermittent moderate left shoulder pain radiating to the left arm. Pain was aggravated by lifting. Simple shoulder test score was 6. XX reported that pain was relieved by ice and physical therapy. Left elbow exam documented tenderness over the lateral epicondyle, decreased left grip strength due to pain, and positive Cozen's test. Left shoulder exam documented greater tuberosity tenderness, full range of motion, and 5/5 left shoulder strength. It was noted that the patient likely had left rotator cuff syndrome and mild lateral epicondylitis. The treatment plan recommended continued physical therapy. The XXXX peer review report indicated that the appeal request for an ultrasound of the left shoulder was not medically necessary. The rationale stated that the request for an "ultrasound" was vague and it was not clear if this was a diagnostic tool, a therapeutic modality, or some other intervention not being described, and there was insufficient clinical data presented to support this request.

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

The Official Disability Guidelines state that diagnostic ultrasound of the shoulder is recommended. MRI or ultrasound could equally be used for detection of full-thickness rotator cuff tears, although ultrasound may be better at picking up partial tears.

This patient presents with persistent intermittent moderate left shoulder pain radiating to the left arm. Pain is aggravated by lifting and relieved by ice and physical therapy. XX has continued to work full duty. Left shoulder exam findings have evidenced greater tuberosity tenderness. Range of motion and strength were reported as normal. There is no documentation of positive orthopedic testing relative to the rotator cuff. An ultrasound of the left shoulder has been requested to rule-out a rotator cuff tear. There is no compelling rationale to support the medical necessity of diagnostic ultrasound in the absence of clear clinical exam findings suggestive of rotator cuff pathology or impingement. There is no evidence that conservative treatment has failed. Therefore, this request for ultrasound of the left shoulder is not medically necessary.

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

- ☐ **ACOEM- AMERICAN 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)**