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An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 02/23/2015

Review Outcome:

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

Family Medicine

Description of the service or services in dispute:

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 female who was injured on xx/xx/xx when she was struck by an iron lid. The patient initially was assessed with a fracture of the distal ulna and tears of the TFCC which required repairs in 12/12. The patient described persistent pain in the left wrist with associated numbness involving the fourth fifth and third fingers of the left hand. Electrodiagnostic studies reportedly showed no evidence for radiculopathy or neuropathy. The patient previously received injections for the left wrist. The patient was followed through 11/14. The last clinical evaluation on 11/19/14 noted tenderness in the ulnar aspect of the wrist with superficial and deep palpation. Repeat injections were recommended at this visit. No specific physical examination findings for the left shoulder was noted. Evaluation on 10/16/14 described pain in the left shoulder. Physical examination showed no evidence of instability with limited active range of motion due to pain. There was tenderness in the anterior and posterior aspect of the left shoulder and tenderness over the acromioclavicular joint and humeral head. Impingement signs were positive with equivocal O'Brien signs. The requested MRI of the left shoulder was denied on utilization or by utilization review on 12/22/14 and 01/28/15 as there was no evidence of acute shoulder trauma or subacute shoulder pain. No red flag conditions were evident. There was no documented physical therapy for the left shoulder and updated physical examination findings were unremarkable.

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

The patient was followed primarily for left wrist complaints following a fracture injury on which required repair. The patient had left shoulder complaints in 10/14 based on evaluation. The last evaluation was not focused on the left shoulder. No updated clinical evaluations for the left shoulder were evident in the clinical documentation submitted for review. There was no clinical documentation of plain film radiographs of the left shoulder ruling out any focal trauma. No red flags were noted and there was no documented conservative treatment dedicated to the left shoulder. Therefore it is the opinion of this reviewer that medical necessity is not established for the request based on guideline recommendations. As such the prior denials remain upheld.

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)