IMedReviews
14785 Preston Road, Suite 550 Dallas, Texas 75254
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DATE OF REVIEW: 10/02/2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

"MRI XX shoulder without contrast as an outpatient" for the patient.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D. Board Certified in Orthopedic Surgery and Sports Medicine.

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)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XXXX who sustained a work injury in a XXXX. Compensable injured body parts include the XX and XX XX and the XX shoulder and wrist. The current request is related to the XX shoulder. According to the clinic note dated XXXX the patient was involved in a XXXX. XXXX was seen at the emergency room after the injury. There is report of x-rays of the XX XX and the XX wrist, but no x-rays mentioned of the XX shoulder. XXXX is reported to have aching, throbbing, and stabbing pain but the location is not specified. XXXX has been previously treated with rest, ice, activity restriction, NSAIDs, muscle relaxers, and opioid pain medication. XXXX is XX at work with some limited restrictions on how long XXXX works. On XXXX exam XXXX was neurovascularly intact in the XX upper extremity. XXXX did not have signs or symptoms of radiculopathy. XXXX had no swelling or effusion in the shoulder. XXXX had full passive range of motion of the shoulder and near full active range of motion. XXXX had 4+/5 strength in the shoulder with abduction and forward flexion and 5/5 strength with other motions. XXXX had positive impingement signs. XXXX had pain and weakness with supraspinatus testing and pain with overhead motion. XXXX had no signs of instability in the shoulder on exam. XXXX was diagnosed with a shoulder strain and the plan was to continue symptomatic treatment with medications, home exercises, and to do an MRI of the XX shoulder without contrast.

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

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Per ODG references the requested "MRI XX shoulder without contrast as an outpatient" for the patient is not medically necessary. With XXXX current clinical picture and XXXX already being XX at work with limited restrictions, the patient does not seem to have symptoms concerning for a significant shoulder structural issue and has had limited conservative treatment to this point. There is no documented negative shoulder x-ray and XXXX has not really done any real physical therapy yet on the shoulder to make an MRI necessary. For this reason, the MRI of the XX shoulder is not certified.

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 KNOWLEDGE BASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW XX 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