**DISCLAIMER**

This Molina Clinical Review (MCR) is intended to facilitate the Utilization Management process. It expresses Molina’s determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Molina) for a particular member. The member’s benefit plan determines coverage. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member’s benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a member’s plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid members. CMS’s Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this Molina Clinical Review (MCR) document and provide the directive for all Medicare members.

**DESCRIPTION OF PROCEDURE/SERVICE/PHARMACEUTICAL**

MRI of the shoulder is useful for looking at the soft tissue structures of the shoulder joint.

**RECOMMENDATIONS**

MRI Imaging can be contraindicated in any of the following circumstances: there is a metallic body in the eye, for magnetically activated implanted devices such as pacemakers and defibrillators, insulin pumps, neurostimulators, and for some types of metal, and aneurysm clipping. The imaging facility should always be consulted with any compatibility questions as the types of metal used and development of MRI compatible devices is continually changing.

Ultrasound has been shown to have similar diagnostic accuracy when compared to MRI and can be considered in lieu of MRI imaging for evaluation of rotator cuff tears, labral injuries, and bicep tendon tears. It is recommended that the ultrasound be completed at a facility competent in performing and interpreting musculoskeletal ultrasound studies. Ultrasound has the benefit of being portable, does not expose the patient to ionizing radiation, and has dynamic imaging capabilities.

**Shoulder Pain**

*Conservative therapy consists of a combination of passive modalities such as rest, ice, activity modification, splinting or crutches, and active modalities such as physical therapy, a supervised home exercise program, and/or failed injections.*
- Initial x-ray has been performed and there has been at least 4 weeks of conservative therapy *
- Hemarthrosis – blood in the joint
- Exam findings suggestive of a rotator cuff tear (Neer, Hawkins, Apley Scratch test, drop arm test, empty can)
- MRI Arthrogram for evaluation of a labral injury (SLAP, Bankart lesion)
- Recurrent dislocations

**Known tumor or mass**
- Initial evaluation of a recently diagnosed cancer
- Follow up of a known tumor or mass after completion of treatment or with new signs/symptoms
- Surveillance of a known tumor or mass according to accepted clinical standards.

**Suspected tumor or mass not confirmed as cancer**
- Evaluation of an abnormality seen on x-ray or other imaging
- Evaluation of an abnormality on physical examination and initial evaluation with x-ray or ultrasound has been completed.

**Evaluation of known or suspected infection**
- Suspected osteomyelitis and initial x-ray has been completed

**Evaluation of known or suspected fractures**
- Suspected fracture and x-ray is non-diagnostic
- Evaluation of fracture involving the joint space

**Pre/Post Procedural**
- Pre-operative evaluation for sizing of custom shoulder replacements
- Post-operative for routine recommended follow up or for potential post-operative complications.
- A repeat study may be needed to help evaluate a patient’s progress after treatment procedure intervention or surgery. The reason for the repeat study and that it will affect care must be clear.

**Other**
- Evaluation of suspected avascular necrosis (AVN) when initial x-ray is non-diagnostic
- Evaluation of known or suspected autoimmune disease and x-rays are non-diagnostic and there is consideration to change the treatment regimen. Imaging should be limited to the most symptomatic joint.
- Evaluation of osteochondral defects or osteochondritis dessicans
- Evaluation of an abnormality seen on other imaging and the diagnosis remains uncertain
- For evaluation of the brachial plexus

**ADDITIONAL CRITICAL INFORMATION**
The above medical necessity recommendations are used to determine the best diagnostic study based on a patient’s specific clinical circumstances. The recommendations were developed using evidence based studies and current accepted clinical practices. Medical necessity will be determined using a combination of these recommendations as well as the patient’s individual clinical or social circumstances.

- Tests that will not change treatment plans should not be recommended.
- Same or similar tests recently completed need a specific reason for repeat imaging.
REFERENCES USED FOR DETERMINATIONS


**CODING INFORMATION:** THE CODES LISTED IN THIS POLICY ARE FOR REFERENCE PURPOSES ONLY. LISTING OF A SERVICE OR DEVICE CODE IN THIS POLICY DOES NOT IMPLY THAT THE SERVICE DESCRIBED BY THIS CODE IS COVERED OR NON-COVERED. COVERAGE IS DETERMINED BY THE BENEFIT DOCUMENT. THIS LIST OF CODES MAY NOT BE ALL INCLUSIVE.

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