



## IMED, INC.

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### Notice of Independent Review Decision

**DATE OF REVIEW:** 06/11/10

**IRO CASE NO.:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Item in dispute: 1 CT Scan with Arthrogram and Aspiration of the Right Shoulder between 5/7/2010 and 07/6/2010.

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

Texas Board Certified Orthopedic Surgeon

**REVIEW OUTCOME**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. IRO Referral documents.
2. Operative report 02/04/09 right shoulder hemiarthroplasty and biceps tenodesis.
3. Records review/peer review, MD 03/08/10.
4. Second opinion MRI right shoulder and CT scan right shoulder, MD 03/18/10.
5. Nurse's chronological list of submitted records 03/19/10.
6. Peer review, MD 03/21/10.
7. Office visit notes, MD 04/01/10.
8. Request for reconsideration 05/12/10.
9. UR determination 05/12/10, DO.
10. Designated doctor evaluation, MD 05/12/10.
11. UR determination, MD 05/19/10.
12. UR reconsideration determination 05/19/10.
13. **Official Disability Guidelines**

**PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a female who was injured on xx/xx/xx. The employee was working and was injured when she was in an elevator and equipment fell hitting her back, shoulder and neck.

The employee underwent right shoulder hemiarthroplasty and biceps tenodesis on 02/04/09.

The employee was determined to reach MMI as of 12/03/09 with 2% impairment rating.

The employee underwent an MRI of the right shoulder on 03/02/10 which was non-diagnostic due to right shoulder prosthesis. CT scan showed unremarkable post hemiarthroplasty appearance right shoulder.

The employee was seen for a new employee initial evaluation by Dr. on 04/01/10. The employee was noted to have had shoulder replacement surgery on 02/04/09 with minimal improvement and is now getting worse. There were no symptoms of infection. The employee complained of pain in his shoulder, pain at night interfering with the ability to sleep, weakness and stiffness in the shoulder. Previous treatment was noted to consist of selective rest, cortisone injection, activity modification, medications, physical therapy, home exercise program, and surgery. Right shoulder examination reported diffuse tenderness over the shoulder. There was swelling present at the proximal humerus and no ecchymosis. There was crepitus present in the subdeltoid bursa and glenohumeral joint. Deformity was noted at the glenohumeral joint. There was atrophy present in the anterior third deltoid, mid third deltoid muscle atrophy and posterior third deltoid atrophy. Supraspinatus atrophy was present and infraspinatus atrophy was present. There was no effusion. Incisions were healed and clean, dry and without evidence of infection. Active range of motion examination was limited by pain.

A request for CT scan with arthrogram and aspiration was reviewed by Dr. on 05/12/10, and was not certified as medically necessary. Dr. noted that records submitted indicated that the employee just underwent right shoulder imaging including MRI and CT on 03/02/10, and there was no evidence of prosthetic loosening or other findings consistent with possible occult infection, findings consistent with a full thickness rotator cuff tear were noted. Dr. noted there was a lack of satisfactory support for repeating CT arthrography with aspiration.

Utilization review determination by Dr. on 05/19/10 determined that the request for CT scan with arthrogram and aspiration right shoulder was not certified. Dr. noted that per medical report of 04/01/10, the employee reports increased pain in the right shoulder. There is diffuse tenderness over the right shoulder on examination with swelling at the proximal humerus and crepitus and a subdeltoid bursa in the glenohumeral joint. Incision site was healed and clean without evidence of infection. Active range of motion was noted to be absent while passive range of motion was limited due to pain. The employee was noted to have had previous CT arthrogram right shoulder but official results were not provided for review. It was also noted there was no objective documentation that there had been a sufficient course of physical therapy and optimized pharmacological treatment prior to contemplating study.

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

Given the clinical data submitted for review, medical necessity is not established for CT scan with arthrogram and aspiration. The employee is noted to have sustained an injury to the right shoulder on xx/xx/xx, and subsequently underwent hemiarthroplasty

right shoulder on 02/04/09. The employee continues to complain of right shoulder pain. MRI and CT scan right shoulder were performed on 03/02/10 and revealed post operative changes. MRI was non diagnostic due to right shoulder prosthesis. CT scan reported intact rotator cuff with no evidence of prosthetic loosening. It was noted there is no evidence of an acute posttraumatic process. There was no evidence of infection or other indication that would necessitate the proposed CT scan with arthrogram and aspiration.

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

**1. Official Disability Guidelines**