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**Notice of Independent Review Decision
Reviewer's Report**

DATE OF REVIEW: July 10, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

CT scan right shoulder.

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

M.D., Board Certified in Radiology.

REVIEW OUTCOME

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

The requested CT scan right shoulder is not medically necessary for evaluation of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 6/16/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 6/19/12.
3. Notice of Assignment of Independent Review Organization dated 6/20/12.
4. Denial documentation.
5. Referrals from MD dated 12/29/11 and 2/08/12.
6. Medical records from MD dated 7/21/11 and 2/08/12.
7. Medical records from MD dated 2/07/12.
8. Medical records from DC dated 12/09/11.
9. Medical records from MD dated 11/10/10.
10. Physical therapy prescription dated 6/24/11.
11. Document entitled Exercise Flow Sheet.
12. Physical therapy reassessment dated 8/19/11.

13. Medical records from Clinic & Rehab dated 12/13/11.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury on xx/xx/xx, resulting in shoulder pain. On 7/21/11, the medical records noted that the patient's treatment included physical therapy and two surgeries. On 7/21/11, he reported 8/10 to 9/10 pain level involving the right shoulder. Physical examination revealed decreased right upper extremity range of motion and 4 of 5 motor strength. On 8/19/11, the documentation indicated the patient had completed 23 physical therapy sessions. He complained of some impingement type shoulder pain with certain positions and movement. The patient was noted to have 170 degrees of passive right shoulder range of motion. On 12/13/11, the medical documentation noted that the patient had 55 degrees of right shoulder internal rotation, 75 degrees of external rotation, 153 degrees of flexion, 46 degrees of extension, 32 degrees of adduction, and 138 degrees of abduction. On 2/07/12, the documentation noted that physical therapy was not performed after the second surgery. The treating provider has ordered a CT scan of the right shoulder.

The URA indicated the patient did not meet Official Disability Guidelines (ODG) criteria for the requested diagnostic procedure. Specifically, the URA's initial denial noted that shoulder CTs are indicated with suspected labral tears, full thickness rotator cuff tears, or SLAP tears when plain x-rays are non-diagnostic. The URA noted that there is no documentation indicating that plain x-rays were non-diagnostic. On appeal, the URA noted that ODG indications for CT include suspected tears of labrum (plain x-ray, then CT), full thickness rotator cuff tear or SLAP tear, clinically obvious or suspected (plain x-ray and ultrasound, then MRI or CT), and recurrent instability. The URA noted that there was no x-ray report submitted for review.

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

The documentation submitted for review indicates that the patient has a history of right shoulder pain and two prior surgical interventions. Official Disability Guidelines (ODG) indicate that CT of the shoulder is indicated for evaluation of suspected labral tears, full thickness rotator cuff tears, or SLAP tears when plain x-rays are non-diagnostic. Thus, ODG criteria recommend CT scans for recurrent instability after plain x-rays. In this patient's case, there were no non-diagnostic plain film radiographs in accordance with evidence-based guidelines. There is a lack of current examination findings to support the requested CT scan in this patient's case. All told, the patient does not meet ODG criteria for the requested CT scan of the shoulder, and the requested diagnostic procedure is not medically indicated for the evaluation of this patient.

Therefore, I have determined the requested diagnostic procedure, CT scan right shoulder, is not medically necessary for evaluation of the patient's medical condition.

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)