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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** February 6, 2013

**IRO CASE #:**

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

CT arthrogram of the shoulder 73201, 23201, and 73040.

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

M.D., Board Certified in Orthopedic Surgery.

**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)

The requested CT arthrogram of the shoulder 73201, 23201, and 73040 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 1/17/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 1/17/13.
3. Notice of Assignment of Independent Review Organization dated 1/17/13.
4. Denial documentation.
5. Medical records dated 12/06/12.
6. Medical records dated 10/26/12.

7. CT of the right shoulder dated 11/24/12.
8. Worker's Compensation Verification Form dated 11/28/12.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reportedly injured his shoulder on xx/xx/xx. He presented to his provider on 10/26/12 and reported right shoulder pain. Physical examination revealed severe pain to palpation at T1-T6 on the right, with a severe amount of tension and stiffness of the upper thoracic muscles and mid-thoracic muscles on the right found on palpation. The medical records noted a positive right shoulder compression test, a positive right supraspinatus press test, and a positive right Apley's test. The documentation noted 70 degrees of right shoulder flexion, 140 degrees of right shoulder abduction, and 4/5 strength. The provider noted that radiographs of the right shoulder revealed no fracture or dislocation. Neuromuscular reeducation and manual therapy was recommended. On 11/24/12, a CT scan of the right shoulder demonstrated underlying degenerative changes of the humeral head, acromioclavicular joint hypertrophy, and pleuroparenchymal scarring. On 12/06/12, the patient reported shoulder pain, especially with overhead motion. The provider recommended a CT arthrogram to evaluate for rotator cuff tear.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested diagnostic procedure. Specifically, the URA's initial denial noted that there was no indication given for a CT arthrogram for this patient who also has thoracic region findings but in whom no MRI contraindications are identified. On appeal, the URA noted that the patient had a CT which was normal, and the medical necessity of the requested diagnostic procedure has not been clearly documented.

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

Official Disability Guidelines (ODG) criteria do not support the requested CT arthrogram of the shoulder in this patient's case. The documents indicate that the patient has complaints of right shoulder pain, and the provider recommended a CT arthrogram of the shoulder to evaluate for rotator cuff tear. However, there was no rationale for why the patient would require a CT arthrogram versus standard MRI to assess for rotator cuff tear. ODG criteria indicate that CT scans of the shoulder are recommended for suspected tears of the labrum, full thickness rotator cuff tear, or SLAP tear not identified on plain x-ray, ultrasound, or MRI, or recurrent instability. The guidelines also state large tears and partial thickness tears are best defined by MRI. Given the lack of rationale and absence of contraindications for MRI, the requested CT arthrogram is not medically indicated for the evaluation of this patient.

Therefore, I have determined the requested CT arthrogram of the shoulder 73201, 23201, and 73040 is not medically necessary for evaluation of the patient's medical condition.

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**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 JUDGMENT, 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)