

MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

Notice of Independent Review Decision

DATE OF REVIEW: February 20, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Computed tomography arthrogram of the left shoulder (CPT codes 73206, 23350, 73201, and 73202).

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 computed tomography arthrogram of the left shoulder (CPT codes 73206, 23350, 73201, and 73202) is not medically necessary for the evaluation of this patient.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 1/31/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 1/31/13.
3. Notice of Assignment of Independent Review Organization dated 1/31/13.
4. Denial documentation.
5. Texas Department of Insurance Report of Medical Evaluation dated 10/26/12.
6. Texas Worker's Compensation Work Status Report dated 10/27/12.
7. Medical records dated 10/26/12.

8. Functional Capacity Evaluation dated 4/03/12.
9. Letter dated 1/31/13.
10. Referral form dated 12/20/12.
11. Medical records dated 12/20/12 and 1/03/13.
12. Medical records dated 12/07/12.
13. MRI of the left shoulder dated 12/27/11.
14. MRI of the cervical spine dated 1/12/12.
15. Undated Nerve Conduction Study.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reportedly sustained an injury on 10/13/11 when he slipped and fell. The medical records noted a SLAP labral tear with rotator cuff impingement. The documentation noted that an MRI in December 2011 revealed a full thickness tear of the distal supraspinatus tendon and infraspinatus tendon. The patient is status post arthroscopic surgery on 3/16/12. On 10/26/12, the medical records noted that the patient had completed over 50 sessions of post-surgical therapy. On 10/26/12, physical examination revealed decreased strength at 4/5 in flexion and extension, and no sensory or motor complications were noted. Grip strength was normal, and range of motion was still decreased in flexion, abduction, and internal rotation. On 12/20/12, the medical records noted that the patient's active range of motion was 0 to 110 degrees, and his passive range of motion was 0 to 120 degrees. The patient demonstrated tenderness in the subacromial area and proximal humerus. A computed tomography arthrogram was recommended. In a letter dated 1/31/13, the provider noted that the patient has had a prior shoulder surgery with metal anchors, and a magnetic resonance arthrogram is contraindicated. The patient has requested coverage for a computed tomography arthrogram of the left shoulder (CPT codes 73206, 23350, 73201, and 73202).

The URA indicated the patient did not meet Official Disability Guidelines (ODG) criteria for the requested diagnostic procedure. Specifically, the URA's initial denial stated that the patient has ongoing pain and weakness, but no indication that a labral tear is being ruled out or suspected. Per the URA, the medical necessity of the request was not clearly demonstrated. On appeal, the URA indicated that there is no indication to repeat the imaging study to rule out a SLAP tear, as this was not addressed at the time of prior surgery. Per the URA, prior MRI showed a SLAP tear and cuff tear.

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

The medical records provided for review fail to provide a rationale for the requested diagnostic procedure. On 12/27/11, an MRI of the left shoulder showed a SLAP superior labral tear extending from anterior to posterior. Per the submitted records, the SLAP tear was not addressed at the time of surgery. Thus, it would still be evident, and there is no rationale for a computed tomography arthrogram at this time. The records provided for review do not document a subsequent injury that might cause a re-tear. The documentation noted significant decreased strength in the left upper extremity. This may be due to deconditioning or lack of conservative

care after surgery. No physical therapy notes were provided to document the scope, breadth, or efficacy of the conservative care following surgery. Per ODG criteria, recurrent instability is also a clinical indication for the requested imaging, and there is no indication for recurrent instability in this patient's case. Therefore, the requested computed tomography arthrogram of the left shoulder (CPT codes 73206, 23350, 73201, and 73202) is not medically indicated and is not supported by ODG.

Therefore, I have determined the requested computed tomography arthrogram of the left shoulder (CPT codes 73206, 23350, 73201, and 73202) 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 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)**