

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 12/17/2013

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/16/2013
Date of Injury:	6/8/2008
IMR Application Received:	8/2/2013
MAXIMUS Case Number:	CM13-0006241

- 1) MAXIMUS Federal Services, Inc. has determined the request for **MR Arthrogram for the right shoulder is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/2/2013 disputing the Utilization Review Denial dated 7/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/26/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **MR Arthrogram for the right shoulder is medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgeon, has a subspecialty in Fellowship trained in Reconstructive Surgery and is licensed to practice in Illinois, Texas, West Virginia. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The Expert Reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and treatments and/or services at issue.

Expert Reviewer Case Summary:

The patient is a 35 year old female who reported an injury on 06/08/2008 after slipping and falling while at work. She had arthroscopic surgery to the shoulder in October 2010, but has continued to complain of pain in that shoulder. An MRI on 09/27/2013 revealed that the patient has a Superior Labrum Anterior and Posterior (SLAP) lesion with an incomplete, full thickness tear to the supraspinatus muscle. The patient has been taking oral and topical analgesics and anti-inflammatories and as participated in multiple sessions of physical therapy; but still has difficulty in completing activities of daily living due to the chronic pain in her shoulder.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Treatment Utilization Schedule (MTUS)
- Medical Records from:
 - X Claims Administrator
 - Employee/Employee Representative
 - Provider

1) Regarding the request for MR Arthrogram for the right shoulder:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) Shoulder Chapter, Arthrography.

The Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG) Shoulder Chapter, Arthrography which is part of MTUS.

Rationale for the Decision:

The employee has continued complaints of right shoulder pain and has been treated with oral, topical, and injectable forms of analgesics. The employee has had an MRI performed on 09/27/2013 which revealed her current diagnosis of a full thickness tear to her supraspinatus muscle. According to Official Disability Guidelines, an arthrogram is preferred over an MRI in order to diagnose full thickness tears and furthermore, arthrography is needed to diagnose labral tears. Therefore, in order for the employee to be diagnosed and then treated appropriately, an arthrogram of the right shoulder is a valid request and is certified. **The request for MR Arthrogram for the right shoulder is medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/cmol

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

[REDACTED]