

Case Number:	CM13-0063039		
Date Assigned:	12/30/2013	Date of Injury:	03/29/2013
Decision Date:	05/12/2014	UR Denial Date:	11/07/2013
Priority:	Standard	Application Received:	12/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Texas. 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 43-year-old female with a date of injury of 03/29/2013 and the mechanism of injury was not provided. Unofficial MRI on 05/06/2013 revealed rotator cuff tendinosis, acromioclavicular joint degenerative joint disease, and mild labral fraying. On 07/18/2013, the injured worker presented reporting progressive problems with pain in the shoulder and failed use of anti-inflammatories, icing, and activity restrictions. On physical examination of the left shoulder, there was no soft tissue swelling and effusion. There was subacromial tenderness noted anteriorly, laterally, and posteriorly over the joint line over the acromioclavicular joint. Impingement sign was positive on the left and supraspinatus sign was positive on the left. Acromioclavicular joint compression test was positive on the left. Range of motion was flexion at 140 degrees and abduction at 100 degrees. Sensation was intact to both upper extremities. Surgical history not provided. A request for authorization on 11/05/2013 indicated the injured worker failed physical therapy, activity restrictions, and cortisone injections with repeat injection and response were not provided.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

REPEAT MRI OF THE LEFT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Shoulder, MRI.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Magnetic resonance imaging (MRI).

Decision rationale: The Official Disability Guidelines recommend magnetic resonance imaging because it demonstrates soft tissue anatomy better. Also, a repeat MRI is not routinely recommended, unless there are significant changes in symptoms and/or significant pathology. The request for a repeat MRI of the left shoulder is non-certified. There was reported residual pain and failed conservative care which included physical therapy and cortisone injections. Guidelines do not recommend a repeat MRI unless there were significant changes in symptoms and/or significant pathology. There was no significant change from the visit on 07/18/2013 and the request for authorization on 11/05/2013 as well as no response noted from the repeat injection. As such, the request is not medically necessary and appropriate.