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| Case Number: | CM14-0127191 | | |
| Date Assigned: | 09/05/2014 | Date of Injury: | 02/21/2012 |
| Decision Date: | 11/24/2014 | UR Denial Date: | 07/26/2014 |
| Priority: | Standard | Application Received: | 08/11/2014 |

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 Orthopedic Surgery, Hand Surgery, and is licensed to practice in South Carolina and Tennessee. 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:

The injured worker is a 52-year-old female who reported an injury on 09/01/2009. The mechanism of injury was not provided. On 06/14/2013, the injured worker presented with right shoulder pain. Diagnoses were rotator cuff tendinopathy, fluid in the subacromial subdeltoid bursa secondary to a small tear, and advanced acromioclavicular joint arthropathy. On examination of the upper extremities, there was 5/5 strength and 2+ tendon reflexes noted. Prior therapy included a left shoulder arthroscopy and medications. The provider recommended an x-ray of the shoulder. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Contrast X-Ray of Shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The request for an x-ray of the shoulder is not medically necessary. The California MTUS/ACOEM Guidelines state routine testing of plain film radiographs of the

shoulder is not recommended during the first month to 6 weeks of activity limitation due to shoulder symptoms. Exception is when a red flag is noted on physical or examination raises suspicion of a serious shoulder condition or referred pain. Criteria for ordering imaging studies include emergence of a red flag, physiologic evidence of a tissue insult or neurovascular dysfunction or failure to progress in a strengthening program intended to avoid surgery and clarification of anatomy prior to an invasive procedure. There was a lack of documentation of previous conservative measures the injured worker underwent and the efficacy of those treatments. Additionally, there was no emergence of a red flag noted upon physical examination. The provider's request does not indicate which shoulder the x-ray was indicated for in the request as submitted. As such, medical necessity has not been established.