

Case Number:	CM14-0064382		
Date Assigned:	07/11/2014	Date of Injury:	06/11/2011
Decision Date:	08/26/2014	UR Denial Date:	04/23/2014
Priority:	Standard	Application Received:	05/07/2014

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 Anesthesiology, has a subspecialty in Pain Medicine 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:

The injured worker is a 53 year old female injured on 06/11/11 due to undisclosed mechanism of injury. Current diagnoses included right shoulder status post arthroscopic surgery on 06/25/12 and bilateral shoulder pain and dysfunction. Clinical note dated 09/25/13 indicated the injured worker presented complaining of constant mild to moderate dull, achy bilateral shoulder pain with associated stiffness, heaviness, and weakness radiating to the bilateral upper extremities. Previous injection to the left shoulder reduced pain for short period of time. Physical examination of bilateral shoulder revealed decreased range of motion, positive +3 tenderness, and positive impingement test. magnetic resonance image Arthrogram of right shoulder revealed no new rotator cuff tear or Superior Labrum Anterior and Posterior region lesion. The initial request for retro request for cervical magnetic resonance image was non-certified on 04/23/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Request for Cervical MRI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neck and Upper Back Complaints, page(s) Magnetic Resonance Imaging (MRI).

Decision rationale: As noted in the current California Medical Treatment Utilization Schedule, magnetic resonance images (MRIs) are recommended for acute neck and upper back conditions when red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection. The clinical documentation failed to establish the presence of these findings. As such, the Retro Request for Cervical MRI cannot be recommended as medically necessary at this time.