MAXIMUS Federal Services

Case Number:	CM14-0075416		
Date Assigned:	07/16/2014	Date of Injury:	11/16/2012
Decision Date:	09/16/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	05/23/2014

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 Preventive Medicine and is licensed to practice in California. 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:

According to the records made available for review, this is a 56-year-old male with a 11/16/12 date of injury, Right shoulder arthroscopic superior labrum anterior and posterior tear repair and rotator cuff tear repair with subacromial decompression and acromioplasty on 1/10/14. At the time (5/6/14) of request for authorization for Magnetic Resonance Imaging (MRI) Left shoulder, there is documentation of subjective (left shoulder pain) and objective (no swelling on right shoulder and right anterior shoulder tenderness)) findings, imaging findings (reported Left shoulder MRI (11/16/12) revealed minimal acromial spurring, rotator cuff tendinosis diffusely, biceps tendinopathy, and evidence of superior labral tear; report not available for review), current diagnoses (left shoulder pain, labral tear, biceps tendinitis, and rotator cuff tendinosis with acromioclavicular joint symptoms), and treatment to date (medications, steroid injections, and physical therapy). Medical report identifies that the requested Left shoulder MRI is to assess surgical treatment options. There is no documentation of a diagnosis/condition (with supportive subjective and objective findings) for which a repeat study is indicated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic Resonance Imaging (MRI) Left 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): 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Magnetic resonance imaging (MRI)Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) reference to American College of Occupational and Environmental Medicine (ACOEM) Guidelines identifies documentation of preoperative evaluation of partial thickness or large full-thickness rotator cuff tears, as criteria necessary to support the medical necessity of shoulder magnetic resonance imaging (MRI). Official Disability Guidelines (ODG) identifies documentation of acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs; subacute shoulder pain, or suspect instability/labral tear, as criteria necessary to support the medical necessity of shoulder MRI. In addition, ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of diagnoses of left shoulder pain, labral tear, biceps tendinitis, and rotator cuff tendinosis with acromioclavicular joint symptoms. In addition, there is documentation of a previous left shoulder MRI. However, despite documentation that the requested Left shoulder MRI is to assess surgical treatment options, there is no documentation of a diagnosis/condition (with supportive subjective and objective findings) for which a repeat study is indicated. Therefore, based on guidelines and a review of the evidence, the request for MRI Left shoulder is not medically necessary.