

Case Number:	CM14-0185141		
Date Assigned:	11/12/2014	Date of Injury:	08/22/2014
Decision Date:	03/17/2015	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	11/05/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New Jersey, New York
 Certification(s)/Specialty: Family Practice

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 44 year old male, who sustained an industrial injury on 8/22/2014, while employed as a stunt manager. He has reported left shoulder pain and his diagnoses have included sprain/strain supraspinatus, infraspinatus. He has had multiple prior accidents from stunts and from motorcycle accidents, including bilateral clavicular fractures and acromioclavicular joint separations. Treatment to date has included conservative measures. On 9/02/2014, the injured worker complains of left shoulder pain, not improving with time and the use of ice. Physical exam revealed no acute distress. Musculoskeletal exam of the left upper extremity revealed normal range of motion and strength. Moderate tenderness to palpation over the biceps groove was noted. Recommendations included continued heat, rest, ibuprofen, and magnetic resonance imaging. Also noted was a recommendation for orthopedic evaluation for possible cortisone injection. A magnetic resonance imaging, performed on 9/02/2014, showed moderate sized minimally retracted full-thickness tear of the distal supraspinatus and moderate subacromial/subdeltoid bursitis. On 9/26/2014, Utilization Review non-certified a retrospective request for magnetic resonance imaging to the left shoulder, citing the ACOEM Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective MRI of the left shoulder (date of service 09/02/2014): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder, MRI

Decision rationale: The request is considered not medically necessary. Because MTUS does not address shoulder MRIs, ODG guidelines were used. ODG states that a shoulder MRI is indicated for acute shoulder trauma, rotator cuff tear/impingement, or if instability and labral tears were suspected. In this limited chart, there is no documentation of significant progression of exam findings or symptoms that would require additional imaging. MRI is not recommended unless symptoms and findings suggest significant pathology. There was no indication of needing surgery. There was also no documentation of failing conservative therapy. Therefore, the request is considered not medically necessary.