

Case Number:	CM14-0199668		
Date Assigned:	12/10/2014	Date of Injury:	04/24/2013
Decision Date:	01/27/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	12/01/2014

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 Physical Medicine Rehab, has a subspecialty in Pain 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:

This is a 62-year-old male with a work related injury dated April 24, 2013. The injury was to the right shoulder and lumbar spine. The worker had surgery to the right shoulder in January 2014. The worker's treatment included physical therapy with hot/cold packs, stretching and electrical stimulation. The worker also had steroid injections. The physician's visit dated October 20, 2014 reflected the worker was complaining of severe right shoulder pain rated five to six on a scale of ten. Pain was described as intermittent pain, without radiation, burning, throbbing, stabbing, aching and sharp in nature. There was also lumbar spine pain rated five and was described as intermittent radiating to the right side associated with cramping, throbbing, stabbing, aching and sharp in the right side and leg. There was limited range of motion with bending, pulling, pushing, lifting and sitting. The worker reported difficulty with completing activities of daily living. Work instructions included working with restrictions to include no overhead reaching and no lifting over 20 pounds. Physical exam was remarkable for right shoulder deficit with abduction and flexion, tenderness in the anterior of the shoulder over the head of the biceps tendon proximally. The lumbar spine reflected loss of lordotic curvature, palpable tenderness worse in the L5-S1 region, range of motion restricted due to pain. Diagnoses at this visit included right shoulder pain, status post right shoulder surgery, right shoulder rotator cuff tear and lumbar spine sprain. The physician documented that the worker was not at the maximum medical improvement and further diagnostic studies were needed to determine the extent of pathology. Treatment plan included x-rays of the right shoulder, the AC joint, the lumbar spine, the right shoulder, continuation of current medications and work status with modified duty status. In the utilization review determination dated November 12, 2014, the request for a magnetic resonance imaging arthrogram of the right shoulder was non-covered as not medically necessary. The rationale for non-coverage was based on the ACOEM, Shoulder, Table 2, Summary of Recommendations,

Shoulder Disorders. The documentation that was reviewed reflected that the physician had recommended magnetic resonance imaging arthrogram of the right shoulder but did not indicate how this would alter the worker's treatment. A peer-to-peer was attempted but was not able to be completed. The request for a magnetic resonance imaging of the right shoulder was non-certified as not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI arthrogram of the right shoulder as an outpatient: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, MR arthrogram

Decision rationale: Regarding the request for MR arthrogram, CA MTUS does not specifically address the issue. ODG notes that they are recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair. Within the documentation available for review, there is no indication of symptoms/findings suggestive of a labral tear or a re-tear of the rotator cuff repair. Additionally, there is no statement identifying the suspicion of either condition or another clear rationale for the study. Furthermore, it appears the requesting physician would like to pursue radiographs to assess the patient's current condition. It seems reasonable to await the outcome of these preliminary studies prior to obtaining on an MRI arthrogram. In light of the above issues, the currently requested MR arthrogram is not medically necessary.