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| Case Number: | CM15-0206059 | | |
| Date Assigned: | 10/22/2015 | Date of Injury: | 12/17/2014 |
| Decision Date: | 12/04/2015 | UR Denial Date: | 10/12/2015 |
| Priority: | Standard | Application Received: | 10/20/2015 |

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: Montana, Oregon, Idaho
Certification(s)/Specialty: Orthopedic Surgery

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 24-year-old male who sustained an industrial injury on 12-17-14. The injured worker reported right shoulder discomfort. A review of the medical records indicates that the injured worker is undergoing treatments for adhesive capsulitis of right shoulder. Medical records dated 10-2-15 indicate pain rated at 7 out of 10. Provider documentation dated 10-2-15 noted the work status as temporary totally disabled. Treatment has included status post right shoulder arthroscopy, shoulder sling, Norco since at least March of 2015, Norflex since at least March of 2015, radiographic studies, and right shoulder magnetic resonance imaging. Objective findings dated 10-2-15 were notable for decreased range of motion. The original utilization review (10-12-15) denied a request for 3T MR arthrogram of the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

3T MR arthrogram of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

Decision rationale: According to the CA MTUS/ACOEM guidelines Chapter 9 Shoulder complaints regarding imaging of the shoulder, page 207-208 recommends imaging for red flag symptoms, physiologic evidence of tissue insult or neurovascular dysfunction or failure to progress in a strengthening program. In addition, imaging such as MRI would be appropriate for clarification of anatomy prior to an invasive procedure. The ODG shoulder section lists the following criteria for ordering a shoulder MRI: Indications for imaging, Magnetic resonance imaging (MRI): Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs; Subacute shoulder pain, suspect instability/labral tear; Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008) In this case, none of the criteria has been satisfied based upon the records reviewed from 10/2/14. The documentation only reports subjective pain with slightly decreased range of motion in a post operative setting. There is no documented objective finding consistent with SLAP tear pathology. The report from the previous MRI has not been submitted and there is no justification to state why another imaging study of the shoulder would be justified post-operatively. Therefore, the request for MR arthrogram of the shoulder is not medically necessary and appropriate.