

Case Number:	CM14-0181707		
Date Assigned:	11/06/2014	Date of Injury:	12/19/2012
Decision Date:	12/09/2014	UR Denial Date:	10/06/2014
Priority:	Standard	Application Received:	10/31/2014

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 Orthopedic Surgery 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 64-year-old female mobile radiology technician sustained an industrial injury on 12/19/12. Injury occurred when a cable broke while she was loading a portable x-ray unit into a van and pulled her left arm back. The 1/23/13 left shoulder MRI revealed prominent tendinopathy of the supraspinatus tendon with mild tendinopathy of the infraspinatus and subscapularis tendons. There was a very small focal partial thickness insertional supraspinatus tear with fraying of the undersurface. There was no high-grade partial or full thickness rotator cuff tear. There was a small amount of fluid in the subacromial/subdeltoid bursa and mild acromioclavicular joint arthrosis. Records indicated that the patient had undergone comprehensive conservative treatment without sustained improvement. The 9/29/14 treating physician progress report cited worsening left shoulder symptoms with a diagnosis of left shoulder impingement syndrome. The treatment plan requested authorization for left shoulder MRI to rule-out progression of rotator cuff tear and to determine the type of surgery. Authorization was also requested for left shoulder rotator cuff repair, subacromial decompression and debridement, and post-operative physical therapy. The 10/6/14 utilization review approved the request for left shoulder rotator cuff repair, subacromial decompression and debridement with 8 visits of post-operative physical therapy. The request for left shoulder MRI was denied as the surgical plan had already been made on the basis of existent imaging and additional imaging was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: MRI (magnetic resonance imaging) of the left shoulder:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Magnetic resonance imaging (MRI)

Decision rationale: The California MTUS guideline criteria for ordering imaging studies include emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, or clarification of the anatomy prior to an invasive procedure. The Official Disability Guidelines state that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings of significant pathology. Guideline criteria have not been met. Left shoulder MRI was requested to assist in surgical planning, but a plan was documented and has been approved based on prior imaging. There is no evidence of a significant change in symptoms or clinical exam findings. There is no compelling reason presented to support the medical necessity of additional imaging prior to arthroscopy. Therefore, this request is not medically necessary.