

Case Number:	CM15-0017397		
Date Assigned:	02/05/2015	Date of Injury:	10/06/2011
Decision Date:	03/30/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	01/29/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 54 year old male, who sustained an industrial injury on 10/06/2011. He is status post left shoulder surgery for a complete tear of the supraspinatus with traction and tendinosis and anterior cervical fusion C5-C7 (undated). The diagnoses have included partial rotator cuff tear. Treatment to date has included medication, specialist consultations and surgical intervention. Currently, the IW complains of constant neck pain rated as 9/10 with radiation to the left upper extremity with numbness and tingling. He reports mid-back pain rated as 6/10 and low back pain rated as 4/10 with radiation down the right lower extremity. He also reported constant shoulder pain rated as 8/10. There is elbow pain, left wrist pain and right ankle pain rated as 7/10. Objective findings included limited cervical and lumbar range of motion. There is not a detailed description of the left shoulder examination. On 1/22/2015, Utilization Review non-certified a request for magnetic resonance imaging (MRI) of the left shoulder without dye, noting that the clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The ACOEM Guidelines were cited. On 1/29/2015, the injured worker submitted an application for IMR for review of magnetic resonance imaging (MRI) joint upper extremity without dye.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder MRI without contrast: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Shoulder chapter, MRI

Decision rationale: This patient presents with neck pain, radiating pain in right lower extremity, left shoulder pain, elbow pain, left wrist pain, right ankle pain, and back pain. The treater has asked for 1 left shoulder MRI without contrast but the requesting progress report is not included in the provided documentation. Review of the reports do not show any evidence of a right shoulder MRI being done in the past. Regarding shoulder MRIs, ACOEM guidelines state: "Routine testing (laboratory tests, plain film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain." The patient is currently working with restrictions. In this case, the patient had an injury to the shoulder and has failed conservative treatment. Review of the reports do not show a prior MRI, and the requested MRI for suspected rotator cuff tear or labral tear is medically necessary.