

Case Number:	CM15-0097501		
Date Assigned:	05/29/2015	Date of Injury:	12/16/2010
Decision Date:	07/07/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	05/21/2015

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, North Carolina
 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 64 year old male, who sustained an industrial injury on 12/16/10. The injured worker was diagnosed as having cervical disc herniation, lumbar disc herniation and possible rotator cuff re-tear of left shoulder. Treatment to date has included oral medications including Prilosec and Advil, extensive physical therapy and multiple epidural injections. Currently, the injured worker complains of pain in cervical spine rated 7-8/10, lumbar spine rated 7-8/10, left shoulder pain rated 8/10 and right shoulder pain rated 4/10. He is currently not working. Physical exam noted tenderness over the midline of cervical spine with asymmetric loss of range of motion and decreased sensation in right C6-7 nerve root distributions, tenderness over the midline of lumbar spine with asymmetric loss of range of motion and tenderness of paraspinal musculature and decreased range of motion of left shoulder with healed previous portals. A request for authorization was submitted for MRA of left shoulder, spine surgery consultation and Kera-Tek gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

MR (magnetic resonance) arthrogram of the left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Guidelines Shoulder (Acute & Chronic).

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

Decision rationale: The request is for a repeat MRA of the left shoulder in a patient with chronic left shoulder pain. A previous MRA of 6/11/13 of the left shoulder showed tendinopathy, tenosynovitis, and superior glenoid fraying consistent with prior arthroscopic debridement. In the interim, the patient has had no significant changes in symptoms and/or physical exam findings. There are also no red flags requiring repeat MRA. Therefore, the request for a repeat MRA of the left shoulder is deemed not medically necessary or appropriate.