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**Notice of Independent Medical Review Determination**

Dated: 11/26/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/18/2013
Date of Injury:	11/9/2007
IMR Application Received:	7/25/2013
MAXIMUS Case Number:	CM13-0003360

- 1) MAXIMUS Federal Services, Inc. has determined the request for **x-ray left knee is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **x-ray right shoulder is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **MRI right shoulder is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/18/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/31/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **x-ray left knee is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **x-ray right shoulder is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request **for MRI right shoulder is medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation 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 treatments and/or services at issue.

### **Expert Reviewer Case Summary:**

The progress report dated 6/12/13 notes that the patient was seen for follow-up regarding left knee and bilateral shoulders. The patient reported his pain at 6/10 and noted that his right shoulder was significantly affecting his ADLs. He had failed cortisone injections to the bilateral shoulders in the past and was considering surgery for the right shoulder. Objective findings did not appear to have significantly changed for the shoulders or the left knee from the 10/17/12 PR-4 report. He reported that he continued with a HEP and stretching routine. Right shoulder MRI dated 5/3/11 showed moderate rotator cuff tendinosis and subacromial bursitis. X-rays of the left knee and bilateral shoulders on 5/18/11 were negative.

Permanent and stationary report dated 10/17/12 notes that recommendations for future medical treatment included surgical intervention for either shoulder if condition deteriorates or the patient elected to proceed with surgery. The exam of the shoulders noted bilateral positive acromial bursitis and a mild decrease in ROM. The examination of the left knee noted ROM at 0 to 120 degrees with painful crepitus throughout, with tenderness to palpation over the medial and lateral joint lines. Gait was mildly antalgic.

### **Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review
- Utilization Review Determination from Claims Administrator
- Employee Medical Records from Claims Administrator
- Employee Medical Records from Employee Representative
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request x-ray left knee :**

##### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Knee Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 13), pages 341-343, which are part of the MTUS.

##### Rationale for the Decision:

The ACOEM guidelines support x-rays for the knee in the presence of any red flags such as new injury, suspected fracture, or suspicion of a new diagnosis. The records submitted and reviewed do not include discussion by the treating provider regarding worsening symptoms of the left knee. Further, the exam findings appear to be unchanged from the previous year. **The request for x-ray left knee is not medically necessary and appropriate.**

#### **2) Regarding the request for x-ray right shoulder :**

##### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), pages 207-209.

##### Rationale for the Decision:

The ACOEM guidelines indicate the primary criteria for ordering imaging studies are: (1) Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems); (2) Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon); (3) Failure to progress in a strengthening program intended to avoid surgery; and (4) Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not

responding to conservative treatment). The records dated 6/12/13 notes that the employee was seeking surgical intervention for the right shoulder as it was now significantly affecting his ability to perform activities of daily living (ADLs) and he had failed steroid injections. Thus, the employee needs an x-ray of the shoulder in anticipation of surgery and for anatomic appreciation. **The request for x-ray right shoulder is medically necessary and appropriate.**

### 3) Regarding the request MRI right shoulder :

#### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), pages 207-209.

#### Rationale for the Decision:

The ACOEM indicate the primary criteria for ordering imaging studies are: (1) Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems); (2) Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon); (3) Failure to progress in a strengthening program intended to avoid surgery; and (4) Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The records dated 6/12/13 notes that the employee was seeking surgical intervention for the right shoulder as it was now significantly affecting his ability to perform ADLs and he had failed steroid injections. Thus, the employee needs an MRI of the right shoulder in anticipation of surgery and for anatomic appreciation. **The request for MRI right shoulder is medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
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