
Notice of Independent Medical Review Determination

Dated: 12/4/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/2/2013
Date of Injury: 4/15/2011
IMR Application Received: 8/6/2013
MAXIMUS Case Number: CM13-0008723

- 1) MAXIMUS Federal Services, Inc. has determined the request for **MRI Arthrogram Right Shoulder is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request **for interferential unit is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/6/2013 disputing the Utilization Review Denial dated 8/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/17/2013. 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 **MRI Arthrogram Right Shoulder** is **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **interferential unit** is **not 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 & Rehabilitation, has a subspecialty in Neuromuscular Medicine 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 patient is a 48 year old male who had a work injury on April 15, 2010. Per records, the exam on May 13, 2013 the patient complains of shoulder and wrist pain. Prior treatment included x-rays, pain medications, physical therapy, Magnetic Resonance Imagin (MRI) of the right shoulder and wrist, modified work duties, and two cortisone injections of the right shoulder. The right shoulder examination reveals + Yergason's test, positive Drop arm test, tenderness of the right shoulder, + impingement and apprehension test. The right shoulder x-ray reveals status post right distal clavicle resection, subacromial decompression which was performed on December 11, 2011. Patient feels as if he never fully recovered from his injury. Despite conservative measures and returning to work he continues to complain of right shoulder and wrist pain. The issue at hand is whether or not MRI arthrogram is medically necessary to rule out labral injury and also whether inferential therapy is necessary.

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 of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for MRI Arthrogram Right Shoulder:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the ACOEM Practice Guidelines, Second Edition (2004), Chapter 11, page 269, Table 11-6, and Chapter 9, page 208, which are part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 9, pps. 208-209, which are part of the MTUS; and the following article: AJR Am J Roentgenol, 2009 Jan 192(1) 86-92. doi 10.2214/AJR 08.1097, which is not part of the MTUS.

Rationale for the Decision:

The employee's symptoms have been going on longer than one month and the surgeon is looking for a specific anatomic defect (i.e. labral tear). Additionally, as shown in AJR Am J Roentgenol, MRI arthrography showed statistically significant increased sensitivity for detection of partial-thickness articular surface supraspinatus tears, anterior labral tears, and superior labrum anterior and posterior (SLAP) tears compared with conventional MRI at 3 T. **The request for MRI Arthrogram Right Shoulder is medically necessary and appropriate.**

2) Regarding the request for interferential unit:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation, page 119, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 118, which is part of the MTUS

Rationale for the Decision:

The guideline lists criteria for the requested treatment, and indicate that it may be appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.).

If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. There is no evidence from the submitted paperwork that employee meets the above criteria. **The request for interferential unit is not 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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/cmol

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.