

Case Number:	CM13-0017091		
Date Assigned:	10/11/2013	Date of Injury:	10/20/2008
Decision Date:	05/05/2014	UR Denial Date:	07/31/2013
Priority:	Standard	Application Received:	08/27/2013

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 Texas. 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:

The patient is a 66-year-old male who reported injury 01/09/2009. The mechanism of injury was a cumulative trauma. The patient had an MRI of the right shoulder on 09/21/2009 that indicated there was an acromion type 1 and the patient was status post partial acromioplasty and acromioclavicular joint reconstruction with a supraspinatus tendon repair. There was no evidence of re-tear, medial retraction, or atrophy. It was indicated the rest of the rotator cuff muscles and tendons were unremarkable and the biceps tendon was normally seen and no SLAP type injury was detected. The patient had an MRI of the left shoulder on 11/14/2012 which revealed a full thickness tear at the supraspinatus tendon insertion to the humeral head with a 0.9 cm medial retraction. There was a "high" riding left humerus seen. No focal bone marrow abnormality was otherwise present. There was a mild amount of fluid seen in the glenohumeral joint, tracking into the subacromial bursa, confirming a rotator cuff tear. There was an acromion type 2 to 3 with moderate proliferative changes in the acromioclavicular joint with impingement upon the supraspinatus muscle/tendon junction with tendinosis changes present. The patient had an EMG on 10/06/2009 which revealed a normal EMG of the bilateral upper and lower extremities. The right nerve conduction studies revealed a mild right median motor neuropathy at the wrist, mild right ulnar motor neuropathy at the elbow, mild right median sensory neuropathy at the wrist and mild right ulnar sensory neuropathy at the wrist. The left upper extremity and bilateral lower extremities nerve conduction studies were within normal limits. The patient had an MRI of the cervical spine on 09/21/2009 which revealed a loss of the intervertebral disc height and disc desiccation changes at C5-6 and C6-7 levels with straightening of normal cervical spine lordosis; C3-6 levels showed a focal central 3 to 4 mm disc protrusion impressing upon the anterior portion of the thecal sac with central cord compression, no cord edema was seen. There was mild right more than left neural foraminal stenosis present and there was no extrusion or sequestration

of disc material; the spinal canal AP diameter at C5-6 was 7 mm. The documentation of 05/20/2013 revealed that the patient did not wish to pursue any further surgical intervention or treatment and wished to close his case. Future medical care revealed the patient may require intermittent medical monitoring for pain medications and no further surgical intervention is indicated. The documentation of 05/28/2013 revealed the patient had an incision in the posterior neck. The shoulder examination revealed the patient had a well healed scar on the right and well healed arthroscopic portals on the left shoulder with range of motion in forward flexion of 165 degrees and abduction of 150 degrees. The patient's diagnoses were noted to include status post right shoulder arthroscopy on 04/27/2010, cervical spine surgery on 04/30/2012, chronic back pain, no improvement, status post left shoulder arthroscopy on 11/20/2012 and status post left shoulder arthroscopic subacromion decompression on 11/20/2012. The request was made for an MRI of the bilateral shoulders to rule out rotator cuff and a CT scan of the cervical spine to rule out nonunion. Additionally, medications and an IF unit as well as treatment with a psychologist were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT SCAN OF THE CERVICAL SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The Expert Reviewer's decision rationale: ACOEM Guidelines indicate the criteria for ordering imaging studies include physiologic evidence of tissue insult or neurologic dysfunction. The clinical documentation submitted for review failed to indicate the patient had physiologic evidence of a definitive neurologic examination. The patient was noted to have a prior electrodiagnostic study and a prior MRI. There was lack of documentation indicating the patient had a significant change in symptomatology as well as new objective findings to warrant a CT scan. Given the above, the request for a CT scan of the cervical spine is not medically necessary.

MRI OF THE BILATERAL SHOULDERS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SHOULDER CHAPTER, MRI

Decision rationale: The Expert Reviewer's decision rationale: Official Disability Guidelines recommend a repeat MRI when there is a significant change in symptoms and/or findings

suggestive of a significant pathology. Clinical documentation submitted for review indicated the patient had prior bilateral MRIs. There was a lack of objective findings to support that the patient had a significant change in symptoms or objective findings. Additionally, there was lack of documentation indicating the patient had a significant change in symptoms and/or findings suggestive of a significant pathology to support the necessity. Given the above, the request for MRI of the bilateral shoulders is not medically necessary.