

<b>Case Number:</b>	CM13-0040827		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	11/02/2006
<b>Decision Date:</b>	05/15/2014	<b>UR Denial Date:</b>	10/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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 Anesthesiology, Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 47-year-old female who reported an injury on 11/02/2006 after performing normal job duties as a bus driver that caused a sudden onset of pain in her left shoulder. The injured worker ultimately underwent surgical intervention in 2008. The injured worker had previously been treated with diagnostic studies to include an MRI of the cervical spine that concluded there was a 1 mm disc bulge at the C5-6 and an MRI of the left shoulder indicating status post surgical intervention with impingement. The injured worker was evaluated on 10/01/2013. It was documented that the injured worker had persistent neck and left arm complaints rated at 8/10 to 9/10. Physical findings included restricted cervical spine range of motion, positive Wartenberg's Wheel Test on the left ulnar and left C6 distribution with positive dysesthesia in the C5 dermatome and deep tendon reflexes described as 2+/4 at the C5-6 and C7 distributions bilaterally. Physical evaluation of the left shoulder documented restricted range of motion described as 160 degrees in flexion, 150 degrees in abduction, 75 degrees in external rotation, and 60 degrees in internal rotation. The injured worker's diagnoses included acromioclavicular joint disorder on the left shoulder, cervical radiculopathy, cervical spine sprain/strain, and shoulder impingement syndrome of the left shoulder, subacromial bursitis on the left, and thoracic sprain/strain. The injured worker's treatment plan included an MR arthrogram of the left shoulder, an MRI of the cervical spine, an x-ray of the cervical spine and left shoulder with continued use of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **MR 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).

**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 requested MR arthrogram of the left shoulder is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has previously undergone an MRI of the left shoulder documenting impingement status post shoulder surgery. California Medical Treatment Utilization Schedule does not address repeat imaging. The Official Disability Guidelines do not support repeat imaging of the left shoulder unless there is a significant change in the injured worker's clinical presentation to support a change in pathology. The clinical documentation fails to provide any evidence that the injured worker has had a significant change in pathology that would warrant an additional MR arthrogram. As such, the requested MR arthrogram of the left shoulder is not medically necessary or appropriate.

## **MRI OF THE CERVICAL SPINE: 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).

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

**Decision rationale:** The requested MRI of the cervical spine is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address repeat imaging. Official Disability Guidelines do not support the use of repeat imaging for the cervical spine unless there is documentation of a significant change in the injured worker's pathology or in the presence of progressive neurological deficits. The clinical documentation submitted for review does not provide evidence that the injured worker has had a significant change in clinical presentation to support the need for an additional MRI. As such, the requested MRI of the cervical spine is not medically necessary or appropriate.

## **X-RAYS OF THE CERVICAL SPINE: 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).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 177-179.

**Decision rationale:** The requested x-rays of the cervical spine are not medically necessary or appropriate. The American College of Occupational and Environmental Medicine do not support routine use of x-rays for the cervical spine unless there is evidence of red flag conditions that support the need for x-rays. The clinical documentation submitted for review does not provide any evidence of red flag conditions to include symptomatology of a tumor or fracture. Therefore, the need for an x-ray of the cervical spine is not medically necessary or appropriate.

**X-RAYS 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).

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

**Decision rationale:** The requested x-ray of the left shoulder is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine do not recommend the routine use of x-rays for the shoulders unless there is suspicion of a fracture or red flag condition. The clinical documentation submitted for review does not provide any physical evidence of a fracture. Additionally, there is no documentation to support a red flag condition. As such, the requested x-ray of the left shoulder is not medically necessary or appropriate.