

<b>Case Number:</b>	CM13-0067828		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	09/09/1997
<b>Decision Date:</b>	05/02/2014	<b>UR Denial Date:</b>	12/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2013

### 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 Pennsylvania. 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 records indicate the claimant is a 69 year old male with a reported injury date of September 9, 1997. The records identify a history of low back and left lower extremity pain. The claimant underwent a previous lumbar laminectomy for L3 through S5 stenosis. The majority of the records focused on complaints and treatment for the lower back. A record from May 8, 2013 indicated the claimant had increased neck pain though no examination findings were documented. The radiographs of the cervical spine showed postoperative changes after a previous C4 through C6 fusion. The current request is for MRI studies of both shoulders and an X-ray of the cervical spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Magnetic Resonance Imaging (MRI) of the left shoulder DOS 09/12/13: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines-Treatment for Workers' Compensation (TWC), Shoulder Procedure, Indications for Imaging- MAGNETIC RESONANCE IMAGING (MRI).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 196, 207-209.

**Decision rationale:** Based upon the ACOEM 2004 Guidelines, the request for a left shoulder MRI is not recommended as medically necessary. The majority of the claimant's treatment records provided for review focus on the lower back and lower extremity. There is no documentation of left shoulder complaints or examination findings nor is there documentation of any conservative care being rendered for either shoulder. In absence of documentation of objective findings on examination and conservative treatment offered for left shoulder symptoms, the records for review do not meet the ACOEM Guidelines for a left shoulder MRI.

**X-ray of the cervical spine DOS 09/12/13:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) Official Disability Guidelines-Treatment for Workers' Compensation (TWC), Neck and Upper Back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165, 177-178.

**Decision rationale:** The request for an x-ray of the cervical spine is not recommended as medically necessary. The ACOEM Guidelines do not recommend x-rays without a trial of conservative treatment for four to six weeks. There is minimal documentation regarding neck symptoms or treatment directed at the symptoms and a prior radiograph of the cervical spine has already been taken and showed postoperative changes. There is no physical examination findings noted for the neck. Overall there is simply insufficient information to support the request for a repeat radiograph of the cervical spine based on the information provided for review.

**Magnetic Resonance Imaging (MRI) of the right shoulder DOS 09/12/13:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208. Decision based on Non-MTUS Citation ODG) Official Disability Guidelines-Treatment for Workers' Compensation (TWC), Shoulder Procedure, Indications for Imaging- MAGNETIC RESONANCE IMAGING (MRI).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 196, 207-209.

**Decision rationale:** Based upon the ACOEM 2004 Guidelines, the request for a right shoulder MRI is not recommended as medically necessary. The majority of the claimant's treatment records provided for review focus on the lower back and lower extremity. There is no documentation of right shoulder complaints or examination findings nor is there documentation of any conservative care being rendered for either shoulder. In absence of documentation of objective findings on examination and conservative treatment offered for right shoulder symptoms, the records for review do not meet the ACOEM Guidelines for a right shoulder MRI.