MAXIMUS Federal Services

Case Number:	CM14-0110315		
Date Assigned:	08/01/2014	Date of Injury:	08/01/2013
Decision Date:	09/22/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/15/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 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 57-year-old male with date of injury of 08/01/2013. The listed diagnoses per [redacted] dated 06/10/2014 are: 1.Bilateral shoulder sprain/strain. 2. Knee, leg sprain/strain, bilateral. According to this report, the patient complains of knee pain at a rate of 6/10, left more than the right. The patient describes his symptoms as dull and burning. He says it is moderately severe. The patient also complains of shoulder pain at a rate of 6/10, right more than the left. The patient describes the pain as sharp and burning. He says that it is moderately severe. The patient states that there is pain on the affected side at the wrist, hand, and fingers. The patient complains that the shoulder pain does radiate to the neck. The physical exam shows there is tenderness on the left trapezius muscle, deltoid muscle, and upper extremity muscles of the left shoulder. There is tenderness on the left subacromial and subdeltoid regions. There is tenderness at the left rotator cuff. There is restricted range of motion on the left shoulder. There is no weakness on the left upper extremities. There is tenderness in the right trapezius muscle, deltoid muscles, and upper extremity muscles. There is tenderness on the right subacromial and subdeltoid regions. There is tenderness to the right rotator cuff. There is restricted range of motion to the right shoulder. There is no weakness on the right upper extremities. The left and right knee is not tender on the bilateral medial joint line. The bilateral knees are not tender on the lateral joint line. McMurray's test is negative. Range of motion on the left knee is diminished. Sensation is intact to light touch and pinprick in the bilateral upper extremities. Bilateral patellar and Achilles deep tendon reflexes are 2/4 bilaterally. Sensation is intact to light touch and pinprick in all dermatomes of the bilateral lower extremities. Radial pulses are 2+ and symmetric. The utilization review denied the request on 06/20/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Bilateral Shoulders: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG-TWC guidelines has the following: (http://www.odg-twc.com/odgtwc/shoulder.htm#Protocol) "Recommended as indicated below. Magnetic resonance imaging (MRI) and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific. Magnetic resonance imaging may be the preferred investigation because of its better demonstration of soft tissue anatomy. (Banchard, 1999) Subtle tears that are full thickness are best imaged by MR arthrography, whereas larger tears and partial-thickness tears are best defined by MRI, or possibly arthrography, performed with admixed gadolinium, which if negative, is followed by MRI. (Oh, 1999) The results of a recent review suggest that clinical examination by specialists can rule out the presence of a rotator cuff tear, and that either MRI or ultrasound could equally be used for detection of full-thickness rotator cuff tears. (Dinnes, 2003) Shoulder arthrography is still the imaging "gold standard" as it applies to full-thickness rotator cuff tears, with over 99% accuracy, but this technique is difficult to learn, so it is not always recommended. Magnetic resonance of the shoulder and specifically of the rotator cuff is most commonly used, where many manifestations of a normal and an abnormal cuff can be demonstrated. The question we need to ask is: Do we need all this information? If only full-thickness cuff tears require an operative procedure and all other abnormalities of the soft tissues require arthroscopy, then would shoulder arthrography suffice? (Newberg, 2000)Indications for imaging -- Magnetic resonance imaging (MRI):- Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs- Subacute shoulder pain, suspect instability/labral tear".

Decision rationale: Official Disability Guidelines (ODG) ODG-TWC guidelines has the following: (http://www.odg-twc.com/odgtwc/shoulder.htm#Protocol) "Recommended as indicated below. Magnetic resonance imaging (MRI) and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific. Magnetic resonance imaging may be the preferred investigation because of its better demonstration of soft tissue anatomy. (Banchard, 1999) Subtle tears that are full thickness are best imaged by MR arthrography, whereas larger tears and partial-thickness tears are best defined by MRI, or possibly arthrography, performed with admixed gadolinium, which if negative, is followed by MRI. (Oh, 1999) The results of a recent review suggest that clinical examination by specialists can rule out the presence of a rotator cuff tear, and that either MRI or ultrasound could equally be used for detection of full-thickness rotator cuff tears. (Dinnes, 2003) Shoulder arthrography is still the imaging "gold standard" as it applies to full-thickness rotator cuff tears, with over 99% accuracy, but this technique is difficult to learn, so it is not always recommended. Magnetic resonance of the shoulder and specifically of the rotator cuff is most commonly used, where many manifestations of a normal and an abnormal cuff can be

demonstrated. The question we need to ask is: Do we need all this information? If only full-thickness cuff tears require an operative procedure and all other abnormalities of the soft tissues require arthroscopy, then would shoulder arthrography suffice? (Newberg, 2000)Indications for imaging -- Magnetic resonance imaging (MRI):- Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs- Subacute shoulder pain, suspect instability/labral tear."

MRI Bilateral Knees: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG-TWC guidelines has the following regarding knee MRI :Recommended as indicated below. Soft-tissue injuries (meniscal, chondral surface injuries, and ligamentous disruption) are best evaluated by MRI. (ACR, 2001) See also ACR Appropriateness Criteria. Diagnostic performance of MR imaging of the menisci and cruciate ligaments of the knee is different according to lesion type and is influenced by various study design characteristics. Higher magnetic field strength modestly improves diagnostic performance, but a significant effect was demonstrated only for anterior cruciate ligament tears. (Pavlov, 2000) (Oei, 2003)Indications for imaging -- MRI (magnetic resonance imaging):- Acute trauma to the knee, significant trauma (e.g, motor vehicle accident), suspect posterior knee dislocation.- Nontraumatic knee pain, child or adolescent: nonpatellofemoral symptoms. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion) next study if clinically indicated. If additional study is needed.- Nontraumatic knee pain, child or adult. Patellofemoral (anterior) symptoms. Initial anteroposterior, lateral, and axial radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional imaging is necessary, and if internal derangement is suspected.- Nontraumatic knee pain, adult. Nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional studies are indicated, and if internal derangement is suspected.- Nontraumatic knee pain, adult - nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement (e.g., Peligrini Stieda disease, joint compartment widening).

Decision rationale: This patient presents with bilateral shoulder and bilateral knee pain. The treater is requesting an MRI of the bilateral knees. The ACOEM Guidelines page 341 to 342 on MRIs for the knees states that special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. In addition, most knee problems improve quickly once any red flag issues are ruled out. For patients with significant hemarthrosis and history of acute trauma, radiography is indicated to evaluate for fracture. Furthermore, ODG states that soft tissue injuries (meniscal, chondral surface injuries, and ligamentous disruption) are best evaluated by an MRI. The records show that the patient has not had an MRI of the bilateral knees. However, the exam does not show any red flag signs, any recent trauma or injury that would warrant imaging studies. Recommendation is for denial.