

Case Number:	CM14-0154982		
Date Assigned:	09/25/2014	Date of Injury:	05/15/2014
Decision Date:	11/18/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/22/2014

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 & Rehabilitation, has a subspecialty in Pain 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 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 68 year old female with an original date of injury on 5/15/2014. The injury occurred when the patient tripped and fell over on the door while carrying a 20 pound desktop, landing on his right side. The patient's industrially related diagnoses include cervical spine disc syndrome, lumbar strain and sprain, cervical radiculopathy, right rotator cuff syndrome, right suprascapular neuropathy, and right carpal tunnel syndrome. Patient has been taking Norco, Gabapentin, and Lidocaine patches. She was also doing physical therapy for an unknown number of sessions. The disputed issue is a MRI of the right shoulder. A utilization review determination on 8/2/2014 had noncertified this request. The stated rationale for the denial was twofold. First, MRI of the shoulder should be considered when symptoms persisted for more than 1 month despite conservative therapy. The patient had physical therapy of an unknown duration, and it was not clear what body region this therapy was directed towards. Secondly, MRI is indicated when acute trauma leading to physical exam findings consistent with rotator cuff tear or rotator cuff instability. The patient's exam finding on 8/6/2014 consisted of reduction of strength in the distribution of right suprascapular nerve, and positive right upper extremity drop test suggest right rotator cuff syndrome and right suprascapular neuropathy. Therefore, the request for MRI of right shoulder was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines- ShoulderMagnetic resonance imaging (MRI)

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

Decision rationale: ACOEM Practice Guidelines 2nd Ed., Shoulder Complaints Chapter, pages 207-209 (as referenced by the California MTUS on page 4 of the Code of Regulations) state: "Routine testing (laboratory tests, plain-film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain. Cases of impingement syndrome are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. Partial-thickness tears should be treated the same as impingement syndrome regardless of magnetic resonance imaging (MRI) findings. Shoulder instability can be treated with stabilization exercises; stress radiographs simply confirm the clinical diagnosis. For patients with limitations of activity after four weeks and unexplained physical findings, such as effusion or localized pain (especially following exercise), imaging may be indicated to clarify the diagnosis and assist reconditioning. Imaging findings can be correlated with physical findings. Primary criteria for ordering imaging studies are: Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems); Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon); Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment)" Official Disability Guidelines: Shoulder Chapter 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. 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. 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. 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? Ultrasonography and magnetic resonance imaging have comparable high accuracy for identifying biceps pathologies and rotator cuff tears, and clinical tests have modest accuracy in both disorders. The choice of which imaging test to perform should be based on the patient's clinical information, cost, and imaging experience of the radiology department. MRI is the most useful technique for evaluation of shoulder pain due to subacromial impingement and rotator cuff disease and can be used to diagnose bursal inflammatory change, structural causes of

impingement and secondary tendinopathy, and partial- and full-thickness rotator cuff tears. However, the overall prevalence of tears of the rotator cuff on MRI is 34% among symptom-free patients of all age groups, being 15% for full-thickness tears and 20% for partial-thickness tears. The results of this study support the use of MRI of the shoulder before injection both to confirm the diagnosis and to triage affected patients to those likely to benefit (those without a cuff tear) and those not likely to benefit (those with a cuff tear). The preferred imaging modality for patients with suspected rotator cuff disorders is MRI. However, ultrasonography may emerge as a cost-effective alternative to MRI. (Burbank, 2008) Primary care physicians are making a significant amount of inappropriate referrals for CT and MRI, according to new research published in the Journal of the American College of Radiology. There were high rates of inappropriate examinations for shoulder MRIs (37%), shoulder MRI in patients with no histories of trauma and documented osteoarthritis on plain-film radiography. See also MR arthrogram. Shoulder Indications for imaging -- Magnetic resonance imaging (MRI): Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs; Sub acute shoulder pain, suspect instability/labral tear; Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. According to ACOEM guidelines, the patient should have had conservative treatment for shoulder pain prior to MRI imaging. This patient has only been on medical treatments, chiropractic manipulations, and topical patches, but no physical therapy notes are available. It is unclear what type of conservative treatment with physical therapy has taken place based upon the submitted documentation. According to various progress notes from 5/2014 to 6/2014, the patient does not demonstrate any shoulder weakness, nor was there any documentation indicating suspected rotator cuff tear or instability. In addition, there was no shoulder x-ray imaging in the provided documentation. The request for a MRI of the right shoulder is not medically necessary.