

<b>Case Number:</b>	CM14-0170662		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	12/23/2013
<b>Decision Date:</b>	11/21/2014	<b>UR Denial Date:</b>	10/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2014

### 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 & Rehabilitation, has a subspecialty in Interventional Spine Pain Management 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 45 years old male with an injury date on 12/23/2013. Based on the 08/27/2014 progress report provided by [REDACTED], the diagnoses are: 1. Degenerative joint disease right knee2. Contracture right knee3. Right hip pain rule out degenerative joint disease4. Acute on chronic lower back pain5. Radiculitis right lower extremity6. Status post lumbar laminectomies x27. Bladder and bower incontinence secondary to spine pathology. According to this report, the patient complains of pain at lumbar spine and right hip. The patient has marked antalgic gait and is ambulating heavily on a cane. Physical exam reveals tenderness and spasm in the paralumbar musculature. Motor testing is 4/5 in all muscle groups of the lower extremities. There were no other significant findings noted on this report. The utilization review denied the request on 10/08/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 07/15/2014 to 08/27/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MR (magnetic resonance) Arthrogram of the the left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Procedure Summary

**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 under MR arthrogram

**Decision rationale:** According to the 08/27/2014 report by [REDACTED] this patient presents with lumbar spine and right hip pain. The provider is requesting MR (Magnetic Resonance) Arthrogram of the left shoulder but the treating physician's report and request for authorization containing the request is not included in the file. The most recent progress report is dated 08/27/2014 and the utilization review letter in question is from 10/08/2014. Regarding MR Arthrogram, ODG guidelines state "Recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair." However, review of reports from 07/15/2014 to 08/27/2014 shows no documentation of the left shoulder. Exam findings of the shoulder were not included in the file for review. In this case, the provider did not provide documentation or indication of a labral tear or a suspected re-tear post-op rotator cuff repair. Without provided the proper documentation, one cannot make an appropriate recommendation. Therefore, this request is not medically necessary.