

<b>Case Number:</b>	CM14-0075281		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	01/08/2007
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	05/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/23/2014

### 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 Occupational 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:

This patient is a 49 year old male who had developed persistent cervical and shoulder pain subsequent to an injury dated 1/8/07. He has been treated with a cervical epidural injection at C6-7. The epidural benefits are not documented in the records reviewed. He has also been treated with left shoulder surgery that included subacromial decompression and debridement. Subsequent to the surgery he has had continued pain in the left shoulder which increased after a reported police incident. The right shoulder also has pain with impingement signs. No specific exam for labral tears is reported in the right shoulder. There is no documented history or exam that pertains to the hips. On 4/14/14 #90 tabs of Hydrocodone were dispensed. On 5/07/14 urine drug screening was negative for opioids.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MR Arthrogram Bilateral Shoulders:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, MR Arthrogram.

**Decision rationale:** The MTUS Guidelines supports the use of appropriate diagnostic testing for ongoing shoulder problems. However, the MTUS Guidelines do not specifically address utilizing MRI Arthrogram techniques. The ODG Guidelines do address this issue and recommend this testing if a repeat tear of the rotator cuff is suspected or if a labral tear is highly suspect. The requesting physician provides adequate justification for a left sided MRI Arthrogram given the history of prior surgery and the increased problems. The requesting physician does not provide adequate justification for a right sided MRI Arthrogram. The right side is not post surgical and a labral tear is not suggested in the physical or diagnosis. The request for bilateral MRI arthrograms is not medically necessary.

**X-ray Left hip:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Hip & Pelvis Chapter, x-ray section.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 20-23.

**Decision rationale:** The MTUS Guidelines state that there needs to be a reasonable amount of medical evaluation and documentation to formulate a diagnosis and need for further testing. The requesting physician does not provide any medical history or exam pertaining to the hips. The request for a left hip X-ray does not meet MTUS standards of care and is not medically necessary.