MAXIMUS Federal Services

Case Number:	CM14-0186595		
Date Assigned:	11/14/2014	Date of Injury:	05/14/1993
Decision Date:	01/05/2015	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	11/10/2014

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 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 55-year-old female with a date of injury of May 14, 1993. The industrial diagnoses include chronic shoulder pain, neck pain, bilateral epicondylitis, bilateral carpal tunnel syndrome, low back pain, and lumbar radiculopathy. With regard to the shoulder, the patient has undergone arthroscopic surgery with subacromial decompression. The disputed request is for MRI arthrogram of the shoulder. A utilization review determination on October 22, 2014 had denied this request. The stated rationale for the denial was that "guidelines you not recommend imaging except for acute and subacute shoulder pain, or for patients with significant changes in symptoms and/or findings suggestive of significant pathology."

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI with Arthrogram Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Shoulder Arthrogram, MR Arthrogram, Magnetic Resonance Imaging.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207- 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, MR Arthrogram.

Decision rationale: The ACOEM Practice Guidelines, Shoulder Complaints Chapter, pages 207-209 state the following: "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 Ray- naud'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); Imaging may be considered for a patient whose limitations due to consis- tent symptoms have persisted for one month or more, i.e., in cases: When surgery is being considered for a specific anatomic defect (e.g., a full-thickness rotator cuff tear). Magnetic resonance imaging 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 it demonstrates soft tissue anatomy better. To further evaluate the possibility of potentially serious pathology, such as a tumor. Selecting specific imaging equipment and procedures will depend on the availability and experience of local referrals. Relying only on imaging studies to evaluate the source of shoulder symp- toms carries a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a finding that was present before symptoms began (for example, degenerative partial thickness rotator cuff tears), and therefore has no temporal association with the symptoms." More detail specification regarding arthrogram of the shoulder is found in the Official Disability Guidelines (ODG), Shoulder Chapter, MR arthrogram Heading which state: "Recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair. MRI is not as good for labral tears, and it may be necessary in individuals with persistent symptoms and findings of a labral tear that a MR arthrogram be performed even with negative MRI of the shoulder, since even with a normal MRI, a labral tear may be present in a small percentage of patients. Direct MR arthrography can improve detection of labral pathology. (Murray, 2009) If there is any question concerning the distinction between a full-thickness and partial-thickness tear, MR arthrography is recommended. It is particularly helpful if the abnormal signal intensity extends from the undersurface of the tendon. (Steinbach, 2005) The main advantage of MR arthrography in rotator cuff disease is better depiction of partial tears in the articular surface. (Hodler, 1992) It may be prudent to include an anesthetic in the solution in preparation for shoulder MR arthrography. (Fox, 2012) See also Magnetic resonance imaging

(MRI)." With regard to the request for MR arthrogram of the shoulder, the ACOEM guidelines specified timing information regarding acute and subacute shoulder pain that is not adequately managed by conservative therapy. In this case, there is documentation of chronic shoulder pain. Therefore the ODG is cited which specify that MR arthrogram of the shoulder can be very sensitive for detection of labral pathology. In the case of this injured worker, the worker has previously undergone arthroscopic subacromial decompression of the shoulder and continues with pain. A progress note on September 10, 2014 documents the requesting providers request for this imaging "in order to determine current postoperative status." The physical examination associated with this note documents trigger points in the upper rhomboids and tenderness in the thoracic spine and Paris scapular muscles. Although the patient continues with persistent shoulder pain, there is no indication specifically of an acute change in pathology which would warrant imaging at this juncture. This request is not medically necessary.