

Case Number:	CM14-0201119		
Date Assigned:	12/11/2014	Date of Injury:	01/14/1993
Decision Date:	02/03/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/02/2014

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 Orthopedic Surgery and is licensed to practice in Minnesota. 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 64 year old female sustained an industrial related injury on 01/04/1993 of unknown mechanism. The results of the injury and initial diagnoses were not provided or discussed. Per the primary treating physician's progress report (10/16/2014), subjective complaints included decreased pain (site not noted) with oral analgesic medication, depression, lack of energy, and decreased libido. There was no objective evaluation or findings for the left shoulder per the PR-2 (10/16/2014). Current diagnoses include status post (S/P) left shoulder surgeries (02/2011, 02/2012 & 04/2014), chronic neck pain, S/P cervical fusion at C6-C7 (1998), S/P cervical discectomy C2 & C7 (1994), partial paralysis of the left upper extremity (unclear etiology), left foot drop since cervical fusion (1998), left knee pain since fall injury (2007), right shoulder pain S/P right shoulder arthroscopic surgery (05/2012), right hip pain secondary to limp due to left foot drop, right trochanteric bursitis, right knee pain, and history of Rheumatoid arthritis. Treatment to date has included left shoulder surgeries (02/2011 & 02/2012), cervical fusion at C6-C7 (1998), cervical discectomy C2 & C7 (1994), right shoulder arthroscopic surgery (05/2012), left shoulder arthroscopy, rotator cuff repair with graft, extensive debridement, blood harvest and "PRP" injection (04/2014) with post-operative physical therapy, oral and topical medications. Other treatments noted included pain medications. There was no recent diagnostic testing submitted or discussed. The MR Arthrogram was requested for the evaluation of left shoulder pain, limitations and weakness. Treatments in place around the time the MR Arthrogram for the left shoulder was requested included oral and topical medications. The injured worker had reported increased left shoulder pain which was resulting in limitations and weakness. However, oral analgesic medications allowed the injured worker to continue with activities of daily living. It was noted that the injured worker had tapered oral pain medications on her own and had continued with normal activities. There were no specific functional deficits

noted. Work functions were unchanged as the injured worker's chronic issues limited her to sedentary work with no overreaching with upper extremities. Dependency on medical care was unchanged. On 11/21/2014, Utilization Review non-certified a prescription for MR Arthrogram of the left shoulder which was requested on 11/17/2014. The MR Arthrogram of the left shoulder was non-certified based on the absence of a complete physical examination of the left shoulder and no significant change in symptoms or findings suggestive of significant pathology. The MTUS ACOEM and ODG guidelines were cited. This UR decision was appealed for an Independent Medical Review. The submitted application for Independent Medical Review (IMR) requested an appeal for the non-certification of MR Arthrogram of the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

MR Arthrogram left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-Shoulder Arthrography

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) Section: Shoulder, Topic: MR arthrogram.

Decision rationale: California MTUS guidelines indicate anatomic definition by means of imaging is commonly required to guide surgery or other procedures. When surgery is being considered for a specific anatomic defect for example 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. The primary reason for ordering imaging is evidence of physiologic tissue insult or failure to progress in a strengthening program or clarification of the anatomy prior to an invasive procedure. ODG guidelines indicate MR arthrography as an option to detect labral tears and for suspected re-tear postop rotator cuff repair. The documentation indicates absence of any red flag conditions that would necessitate imaging. There is no evidence of a substantial change in the physical findings. There are no indications for a repeat surgical procedure. The injured worker had initially reported more pain but subsequently there was some improvement documented and she had tapered the pain medication. There was no new functional deficit noted. Specific new physical findings suggesting need for surgical procedures or additional imaging were not reported. As such, no additional surgery was felt to be needed and the repeat MR arthrogram was not indicated. Based upon the above, the request for MR arthrogram of the left shoulder did not meet the guideline criteria. Therefore, this request is not medically necessary.