

Case Number:	CM15-0105371		
Date Assigned:	06/09/2015	Date of Injury:	08/17/2014
Decision Date:	07/10/2015	UR Denial Date:	05/20/2015
Priority:	Standard	Application Received:	06/01/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 39 year old female, who sustained an industrial injury on 8/17/2014. She reported injury while moving shelves. The injured worker was diagnosed as having bilateral shoulder adhesive capsulitis, cervical sprain/strain and bilateral rotator cuff sprain/strain. There is no record of a recent diagnostic study. Treatment to date has included therapy and medication management. In a progress note dated 5/12/2015, the injured worker complains of neck pain and shoulder pain, rated 8/10. Physical examination showed posterior cervical tenderness and bilateral shoulder tenderness. The treating physician is requesting bilateral shoulder magnetic resonance imaging with and without contrast and a computed tomography scan with 3D rendering of the neck and bilateral shoulders.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI with and without contrast of the bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209,213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Magnetic resonance imaging (MRI), MR arthrogram.

Decision rationale: ACOEM states: 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 Reynaud'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). ODG states: Indications for imaging Magnetic resonance imaging (MRI): Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs; Subacute 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. (Mays, 2008) MTUS is silent specifically regarding MRI Arthrogram of the shoulder. Therefore, other guidelines were utilized. ODG states regarding MR Arthrogram of the Shoulder, 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. The treating physician has not provided evidence of red flags to meet the criteria above. As such, the request for MRI with and without contrast of the bilateral shoulders is not medically necessary at this time.

CT scan with 3D rendering of neck and bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, 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) Neck and Upper Back (Acute & Chronic), Shoulder (Acute & Chronic), Computed tomography (CT).

Decision rationale: ODG states: Not recommended except for indications below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. (Anderson, 2000) (ACR, 2002) See also ACR Appropriateness Criteria. MRI or CT imaging studies are valuable when potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior

to surgery. MRI is the test of choice for patients who have had prior back surgery. (Bigos, 1999) (Colorado, 2001) For the evaluation of the patient with chronic neck pain, plain radiographs (3-view: anteroposterior, lateral, open mouth) should be the initial study performed. Patients with normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging. If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. (Daffner, 2000) (Bono, 2007) CT scan has better validity and utility in cervical trauma for high-risk or multi-injured patients. (Haldeman, 2008) Repeat CT is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation where MRI is contraindicated). (Roberts, 2010) Indications for imaging, CT (computed tomography): Suspected cervical spine trauma, alert, cervical tenderness, paresthesias in hands or feet; Suspected cervical spine trauma, unconscious; Suspected cervical spine trauma, impaired sensorium (including alcohol and/or drugs); Known cervical spine trauma: severe pain, normal plain films, no neurological deficit; Known cervical spine trauma: equivocal or positive plain films, no neurological deficit; Known cervical spine trauma: equivocal or positive plain films with neurological deficit". ODG states in relation to shoulder CT "Recommended as indicated below. In proximal humeral fractures (also called a broken shoulder) a CT should be performed, independently of the number of fractured parts, when the proximal humerus and the shoulder joint are not presented with sufficient X-ray-quality to establish a treatment plan. Conventional X-rays with AP view and a high-quality axillary view are useful for primary diagnostics of the fracture and often but not always show a clear presentation of the relevant bony structures such as both tuberosities, the glenoid and humeral head. CT with thin slices technology and additional 3 D imaging provides always a clear presentation of the fractured region. (Bahrs, 2009) Indications for imaging, Computed tomography (CT): Suspected tears of labrum; Plain x-ray, then CT; Full thickness rotator cuff tear or SLAP tear clinically obvious or suspected; Plain x-ray and ultrasound, then MRI or CT; Recurrent instability; CT arthrogram (Newberg, 2000). In proximal humeral fractures when the proximal humerus and the shoulder joint are not presented with sufficient X-ray-quality to establish a treatment plan. (Bahrs, 2009)" The treating physician has not provided documentation of a new injury, re-injury, a change in symptoms, cervical trauma or instability, or documentation of focal neurologic deficits to meet the above guidelines. Additionally, no x-rays were provided. As such, the request for C T scan with 3D rendering of neck and bilateral shoulders is not medically necessary.