

<b>Case Number:</b>	CM14-0217108		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	03/03/2010
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	12/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/29/2014

### 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. 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 & Gen Prev Med

### 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 was injured 3/3/10 resulting from a slip and fall on a wet floor. She sent straight down into a sitting position landing on her elbow and buttocks. She hit the back of her head on a metal rack and the back of her left shoulder. The injured worker had underlying cervical degenerative disc disease without cervical radiculopathy. She complained of a sharp, burning, throbbing, pressure-like pain in the back of her head with radiation to the left shoulder. She has left sided numbness and tingling in her arms, fingers and toes. The left shoulder exhibits weakness and instability with popping. In addition the low back pain radiates bilaterally into hips, buttocks, left groin and leg. Her pain intensity is 9/10. She has balance and bowel control issues. Her range of motion is limited. Her medications include Vicodin, Flexaril, Verapamil, Lipitor and hydrochlorothiazide. The pain medications help at times. Her activities of daily living, driving and sleep are compromised because of the pain. She uses a cane for ambulation. Physical exam revealed significant tenderness in the midline of the lumbar spine and paralumbar musculature. Cervical, lumbar right and left range of motion are decreased. Electromyography (EMG 8/11) indicated moderate carpal tunnel syndrome bilaterally, left greater than right. On 9/11 she underwent left shoulder surgery and repair with subacromial decompression and bursectomy for left shoulder impingement with partial rotator cuff tear. After physical therapy post-operatively her shoulder symptoms improved. EMG 11/11 indicated chronic left L5 radiculopathy, axonal polyneuropathy and left Neuralgia paresthetica. She continued to experience low back pain and underwent a series of lumbar epidural steroid injections midline to

L3-4 and left L5-S1 from 2012 to 2013 after which her right leg became painful. The injections did not relieve her symptoms. MRI of the lumbar spine (5/12) indicated multilevel disc desiccation with disc bulge with central canal and foraminal stenosis (with significant signs of radiculopathy), multilevel facet arthropathy and scoliosis. Left hip radiograph 6/12 revealed left hip osteoarthritis. Radiographs (9/22/14) reveal lumbar multilevel degenerative disc disease at L2-3 and L3-4 and thoracic degenerative changes. Diagnoses include myoligamentous strain of the thoracic and lumbar spine; status post left shoulder arthroscopic surgery. The injured worker has been off work since the injury and retired in 2012. On 12/17/14 Utilization Review (UR) non-certified the request for open MR Arthrogram of the left shoulder based on no documentation indicating possible tissue insult or neurovascular dysfunction of the left shoulder which would meet guideline specifications. The guidelines referenced were ACOEM; Shoulder Chapter and ODG. MRI of the lumbar spine was approved per UR.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Open MR Arthrogram Left Shoulder:** 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 Shoulder (Acute & Chronic), MR arthrogram

**Decision rationale:** 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." There is no documentation of red flag diagnoses or neurovascular deficits to meet the above guidelines. As such, the request for MRI Arthrogram Left Shoulder is not medically necessary at this time.