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| <b>Case Number:</b>   | CM13-0045667 |                              |            |
| <b>Date Assigned:</b> | 12/27/2013   | <b>Date of Injury:</b>       | 10/19/2006 |
| <b>Decision Date:</b> | 04/18/2014   | <b>UR Denial Date:</b>       | 10/01/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/24/2013 |

### 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 New York. 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 patient is a 51-year-old individual who sustained an injury on October 19, 2006. The patient complained of left hand and wrist pain. The patient had associated symptoms of weakness numbness and swelling. The patient also had right hand pain. The patient also had left elbow pain. The patient was diagnosed with reflex sympathetic dystrophy, impingement syndrome, and the patient had arthroscopic right acromioplasty. The patient was also diagnosed with adhesive capsulitis. X-rays of the left shoulder showed good glenohumeral relationship and no evidence of heterotopic ossification. Left shoulder CT arthrogram was requested to assist with confirming diagnostic impressions and clinical decision making. At issue is whether left shoulder CT arthrogram is medically necessary at this time.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**A CT ARTHROGRAM OF THE LEFT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Arthrography.

**Decision rationale:** This patient does not meet established criteria for shoulder CT arthrogram at this time. The patient has multiple orthopedic complaints. The medical records do not contain a recent trial and failure of conservative measures for left shoulder pain to include physical therapy. Also shoulder CT arthrogram is intended as a preoperative evaluation study. This patient has chronic regional pain syndrome and reflex sympathetic dystrophy. His condition has not improved with surgery. In addition, a well-documented physical examination of the shoulder is not present in the medical records. Guidelines for CT arthrogram of the shoulder are not met.