

<b>Case Number:</b>	CM15-0200834		
<b>Date Assigned:</b>	10/15/2015	<b>Date of Injury:</b>	11/02/2013
<b>Decision Date:</b>	11/25/2015	<b>UR Denial Date:</b>	09/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/13/2015

### 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: New Jersey, New York  
 Certification(s)/Specialty: Family Practice

### 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 33 year old male who sustained an industrial injury on 11-02-2013. A review of the medical records indicated that the injured worker is undergoing treatment for right rotator cuff tendinitis, rule out internal derangement and right wrist tendinitis. According to the treating physician's progress report on 08-31-2015 and 07-27-2015, the injured worker continues to experience right shoulder pain. Examination of the right shoulder demonstrated tenderness anteriorly and laterally with flexion and abduction at 160 degrees, external rotation at 80 degrees and extension at 30 degrees and adduction at 40 degrees. Motor strength was 5 minus out of 5. Prior treatments have included ice therapy, home exercise program and medications. No diagnostic studies were noted in the review. Current medication was noted as Ultram. Treatment plan consists of orthopedic shoulder evaluation, continuing home exercise program, ice therapy and the current request for a right shoulder magnetic resonance imaging (MRI). On 09-14-2015 the Utilization Review determined the request for right shoulder MRI was not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, MRI.

**Decision rationale:** The request is considered not medically necessary. Because MTUS does not address shoulder MRIs, ODG guidelines were used. ODG states that a shoulder MRI is indicated for acute shoulder trauma, rotator cuff tear/impingement, or if instability and labral tears were suspected. There is no documentation of significant progression of exam findings or symptoms that would require imaging. Rotator cuff maneuvers were not documented. MRI is not recommended unless symptoms and findings suggest significant pathology. Therefore, the request is not medically necessary.