

<b>Case Number:</b>	CM15-0011941		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	09/05/2012
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 54 year old female who sustained an industrial related injury on 9/5/12. The injured worker had complaints of shoulder pain. Treatment included a right arthroscopic rotator cuff repair with distal clavicle resection on 12/3/13 and post-operative physical therapy. Medications included Ultram, Ibuprofen, Naproxen, and Capsaicin cream. Physical examination findings included a positive impingement test for the right upper extremity. The diagnosis was noted to be rotator cuff tear. The treating physician requested a MRI arthrogram of the right shoulder under fluoroscopic guidance. On 1/14/15 the request was non-certified. The utilization review physician cited the Medical Treatment Utilization Schedule guidelines and noted there was already imaging evidence of a re-tear and there was no reason for the injured worker to undergo an additional advanced imaging study to assess for the absence or presence of tears. Therefore the request was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI Arthrogram of the right shoulder under fluoroscopic guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), shoulder chapter, MRI

**Decision rationale:** This patient is status post right rotator cuff repair on 12/3/13 and presents with continued bilateral shoulder pain. The current request is for MRI Arthrogram of the right shoulder under fluoroscopic guidance. ACOEM Guidelines has the following regarding shoulder MRIs, page 207 to 208, Routine testing, laboratory test, plain film radiographs of the shoulder, and more specialized imaging studies are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain. ODG guidelines under the shoulder chapter states that MRI and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy. This patient already had an MRI on 2/5/14 which showed prior repair was intact and the treating physician does not explain why another set of MRI's are required. There are no new injuries, no significant change in the symptoms and no new findings on examination. This request is not medically necessary.