

<b>Case Number:</b>	CM15-0033653		
<b>Date Assigned:</b>	02/27/2015	<b>Date of Injury:</b>	03/18/2004
<b>Decision Date:</b>	04/13/2015	<b>UR Denial Date:</b>	02/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/23/2015

### 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:

This 59 year old male sustained a work related injury on 03/18/2014. According to a progress report dated 01/22/2015, the injured worker reported worsening of right shoulder pain that interfered with use. Diagnoses included thoracolumbar spine strain, compression fracture at L1, lumbar disc protrusion at L4-L5 and L5-S1 with annular tear, status post right-sided laminectomy and discectomy L5-S1, right rotator cuff tendinitis and impingement syndrome, status post right shoulder operative arthroscopy with subacromial decompression, rotator cuff debridement and mini-Mumford procedure, resolved contusion straining injury of both knees/toes and status post right shoulder arthroscopy on 11/02/2010. Plan of care included continued psychiatric care, Tramadol, authorization for MR Arthrogram right shoulder to guide treatment. Physical examination of the right shoulder revealed well-healed non-tender arthroscopic incisions. There was no soft tissue swelling or infection. There was no tenderness to palpation. There was no AC joint or bicipital tenderness and no irritability. There was a negative impingement sign, grind sign, apprehension sign and relocations sign. There was no shoulder instability. There were no paresthesias with shoulder motion. There was grade IV/V rotator cuff/deltoid/ biceps strength. Range of motion was 150 with flexion, 145 degrees with abduction, 40 degrees with extension, 45 degrees with external rotation, 40 degrees internal rotation and 30 degrees adduction. There was a greater passive range of motion without obvious adhesive capsulitis. On 02/13/2015, Utilization Review non-certified one MR Arthrogram of right shoulder. The rationale was not provided. The decision was appealed for an Independent Medical Review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) MR arthrogram of right shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** This patient presents with right shoulder pain. The status is post right shoulder arthroscopy with subacromial decompression and rotator cuff debridement on 1/27/06. The current request is for ONE 1 MR ARTHROGRAM OF RIGHT SHOULDER. Request for Authorization (RFA) provided is dated 1/22/15. ACOEM Guidelines has the following regarding shoulder MRIs, page 207 to 208 states: 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. The ODG for MR arthrogram states, "Recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair." The treating physician states that he would like an MR arthrogram of the right shoulder to help guide our treatment. Examination on this day revealed no swelling, no tenderness, negative impingement sign, grind sign, apprehension sign and relocation sign. No instability was note and no paresthesias. There was grade IV/V rotator cuff strength and decreased range of motion without obvious adhesive capsulitis. In this case, there are no significant findings on examination to warrant an MR arthrogram of the right shoulder. There is no concern for labral tears or re-tear following the rotator cuff repair. This request IS NOT medically necessary.