MAXIMUS Federal Services

| Case Number: | CM15-0074159 | | |
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| Date Assigned: | 04/24/2015 | Date of Injury: | 09/28/2010 |
| Decision Date: | 05/27/2015 | UR Denial Date: | 03/19/2015 |
| Priority: | Standard | Application Received: | 04/17/2015 |

## 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: Internal Medicine

## 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 (IW) is a 42 year old female who sustained an industrial injury on 09/28/2010. She reported left shoulder pain. The injured worker was diagnosed as having: Left shoulder pain, weakness, rotator cuff tendinitis; Left elbow lateral epicondylitis. Treatment to date has included physical therapy and medications. In the exam of 03/04/2015, the injured worker complained of pain in the front in the left shoulder. The examination of the bilateral shoulders revealed full active range of motion with no strength deficit. There was pain on the left shoulder. There was no popping with anterior posterior translation of the humeral head. The IW rated her pain as 8 on a scale of 10. The pain had been responsive to non-steroidal anti-inflammatories and to physical therapy. The IW stopped taking oral anti-inflammatory for the shoulder and was using a topical gel on the shoulder that was prescribed for a knee injury. The treatment plan is to have the worker continue a home exercise program and to repeat a MRI of Left Shoulder with Arthrogram and MRI Left Shoulder without Contrast to check for additional pathology that would lead to a recommendation of surgery. Work restrictions were instituted, and a follow-up appointment planned.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of Left Shoulder with Arthrogram:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 195-214.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses shoulder magnetic resonance (MR) arthrogram. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 9 Shoulder Complaints indicates that MRI magnetic resonance imaging and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy. Magnetic resonance imaging is the preferred investigation because it demonstrates soft tissue anatomy better. Risk of complications, e.g., infection, radiation, is highest for contrast CT or arthrography. Arthrography may be considered preoperatively only if MRI is unavailable. Routine MRI or arthrography for evaluation without surgical indications is not recommended. The primary treating physician's progress report dated 3/4/15 documented the diagnoses of pain shoulder joint, left shoulder pain, weakness, rotator cuff tendinitis. Physical examination of bilateral shoulders demonstrated full active range of motion. Left shoulder demonstrated pain. Strength was 5/5. The utilization review decision letter dated 3/16/15 documented the certification of MRI of the left shoulder. The 3/4/15 physical examination demonstrated full active range of motion and normal 5/5 strength. ACOEM indicates that MRI magnetic resonance imaging and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy. Magnetic resonance imaging is the preferred investigation because it demonstrates soft tissue anatomy better. Risk of complications, e.g., infection, radiation, is highest for contrast CT or arthrography. Arthrography may be considered preoperatively only if MRI is unavailable. Routine MRI or arthrography for evaluation without surgical indications is not recommended. Because the physical examination demonstrated full active range of motion and normal 5/5 strength, the request for arthrogram is not supported. Because MRI was certified on 3/16/15, the request for arthrogram is not supported by ACOEM guidelines. Therefore, the request for arthrogram is not medically necessary.