

Case Number:	CM13-0036396		
Date Assigned:	12/13/2013	Date of Injury:	05/17/2013
Decision Date:	02/18/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation and is licensed to practice in California, Maryland, Florida, and Washington DC. 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 physician 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 claimant is a 55 years old male, who reports that on May 10, 2013, while in the scope of his employment for [REDACTED], he sustained a work-related injury while performing his usual and customary duties as a laborer. He reports that while lifting heavy metals with a group of three, the metal slipped from the two other guys and he held onto it and he popped his shoulder. Immediately afterwards, he noted right-sided headache and pain in right side of his jaw, neck, back, upper hand, forearm and hand. The injury was witnessed by [REDACTED] and was reported to his supervisor. On May 17, 2013, the patient was seen at [REDACTED] in the [REDACTED] who referred him for an MRI and prescribed medication. He received cortisone injection into his right shoulder, which helped him. MRI w~ts pP.rfnnned in the [REDACTED]. Objective Findings: Right Shoulder: On examination of the right shoulder, there was tenderness to palpation, spasm and swelling noted over the deltoid complex. Neer and Hawkins-Kennedy tests were positive. Manual muscle testing revealed 4/S strength with flexion, extension, abduction, adduction, internal rotation and external rotation. Range of motion was restricted due to pain and spasm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic resonance imaging (MRI) of right shoulder: Overturned

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): 2098, Chronic Pain Treatment Guidelines.

Decision rationale: The Physician Reviewer's decision rationale: CA-MTUS (Effective July 18, 2009) ECOEM (2004) page 208, section on shoulder complaints stated: Routine testing (laboratory tests, 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. Cases of impingement syndrome are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. Partial-thickness tears should be treated the same as impingement syndrome regardless of magnetic resonance imaging (MRI) findings. Shoulder instability can be treated with stabilization exercises; stress radiographs simply confirm the clinical diagnosis. For patients with limitations of activity after four weeks and unexplained physical findings, such as effusion or localized pain (especially following exercise), imaging may be indicated to clarify the diagnosis and assist reconditioning. Imaging findings can be correlated with physical findings. Primary criteria for ordering imaging studies are: - Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems) - Physiologic evidence of tissue insult or neurovascular dysfunction (e.g. cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon) - Failure to progress in a strengthening program intended to avoid surgery. - Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tears not responding to conservative treatment) MRI dated 6/28/2013, from Temecula Valley Imaging, reveals findings compatible with a partial thickness undersurface tear in the distal supraspinatus tendon with mild interstitial tearing of the subscapular and underlying rotator cuff tendinosis. No full thickness tear is indentified. There is a tear of the anterior inferior labrum with associated paralabra 1 cysts with flattening of the humeral head posterior superiorly. There is an intact long head of biceps tendon. Therefore the request for MRI of the right shoulder is medically necessary.