

<b>Case Number:</b>	CM14-0008614		
<b>Date Assigned:</b>	02/12/2014	<b>Date of Injury:</b>	05/13/2010
<b>Decision Date:</b>	06/24/2014	<b>UR Denial Date:</b>	01/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2014

### 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. The expert reviewer is Board Certified in Neurological Surgery and is licensed to practice in California. 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/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 injured worker is a 49-year-old female with a date of injury of May 13, 2010. The mechanism of injury is described as an injury to the left shoulder when placing handcuffs. A progress note dated August 14, 2013 is provided for review in support of the request indicating the injured's shoulder had been bothersome for the past 5-6 months. The symptomatology was worse with overhead activity. An occasional aching sensation was noted with sleep. No neurological symptoms were noted in the left shoulder. Physical examination revealed reduced range of motion (active) and passively. The injured worker was able to get 160° of flexion and abduction. External rotation was normal and internal rotation was to L3. Neer and Hawkins impingement tests were positive and tenderness was noted at the subacromial bursa, bicipital groove, and acromioclavicular (AC) joint. Motor testing was reported as 5/5 and sensation was intact. X-rays noted small calcific tendinitis. The diagnosis noted was left shoulder impingement. A left shoulder corticosteroid injection was provided, as well as an in-home stretching program. Physical therapy was recommended, as well as anti-inflammatory medications, and analgesics. The record indicates if no improvement is noted an MRI will be recommended. A September 17 physical therapy progress report indicates the injured had been initially seen in physical therapy on August 22, 2013. A total of 5 visits were attended and the injured was considered to have made slow progress. An M.D. progress report from December 2013 indicates the injured had no relief from the injection in August. The injured's left shoulder internal rotation improved, but the passive left shoulder abduction and flexion decreased. The record indicates a concern for development of frozen shoulder and additional physical therapy is recommended with a focus on frozen shoulder protocols and a daily home exercise program. The diagnosis noted is adhesive capsulitis.

## **IMR ISSUES, DECISIONS AND RATIONALES**

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

### **ONE MRI OF THE LEFT SHOULDER WITH CONTRAST: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

**Decision rationale:** The California guidelines do not support specialized imaging studies prior to six weeks of activity limitation unless a red flag is noted. After six weeks of activity limitation, support of specialized imaging studies may be considered when physiologic evidence of neurovascular dysfunction is noted, there is failure to progress in a strengthening program that is intended to avoid surgery, or for clarification of anatomy prior to an invasive procedure. The guidelines recognize the value of MR Arthrogram to evaluate for labral tears, or rotator cuff tears following rotator cuff repair. The record provides no indication that the claimant has undergone rotator cuff repair and the physical exam findings for labral pathology are unremarkable. There is no documentation in the medical record to substantiate the necessity of an MR arthrogram, rather than MRI, for the injured. In the absence of the appropriate clinical documentation to support the necessity of the diagnostic study, there is insufficient clinical data to support this request. The request is not medically necessary or appropriate.