

<b>Case Number:</b>	CM14-0161053		
<b>Date Assigned:</b>	10/06/2014	<b>Date of Injury:</b>	07/31/2013
<b>Decision Date:</b>	10/31/2014	<b>UR Denial Date:</b>	09/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2014

### 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 Orthopedic Surgery and is licensed to practice in Texas. 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 35-year-old male with a date of injury on 7/31/13. He was working as a recycling clerk when he twisted his right wrist dumping barrels of recyclables. His past medical history was positive for severe attention deficit disorder and cigarette use. His past surgical history was positive for right carpal tunnel release on 2/8/06, left carpal tunnel release on 3/23/05, and right shoulder arthroscopic synovectomy on 1/31/07. The 8/23/13 right wrist magnetic resonance imaging impression documented trace fluid adjacent to the extensor pollicis longus and extensor carpi radialis brevis tendons at the radiocarpal joint dorsally, consistent with minimal tenosynovitis. The 8/26/14 right shoulder magnetic resonance imaging noted impingement anatomy with downsloping of the distal clavicle, but without significant bony spurring. Conservative treatment included subacromial corticosteroid injection on 6/23/14 that did not provide relief. Physical therapy was requested on multiple occasions for the shoulder but was not approved. The 9/16/14 orthopedic report documented that the injured worker had been released to modified work on 8/18/14 with lifting and overhead work restrictions, with total work limited to 5.5 hours per day. He reported he was unable to handle the hours and requested restrictions be dropped to 4 hours per day. He complained of excruciating shoulder pain. The pain was worse with motion and improved with ibuprofen. He reported associated edema, catching, popping, instability, weakness, and abnormal noises with shoulder motion. The physical exam documented an unremarkable gross exam with no obvious swelling. There was an exaggerated pain response (painful Facies) on palpation of the lateral edge of the acromion and subjective pain with elevation of the arm above shoulder level. The Neer's test was positive and the drop arm test was negative. There was no pain to palpation of the bicipital groove tendon. The range of motion was full when attention was distracted and he able to push off exam table with both arms. The diagnosis was shoulder joint pain and impingement syndrome. The treating

physician discussed the fact that the pain displayed did not necessarily fit the physical findings. The magnetic resonance imaging was reviewed with the radiologist who recommended an arthrogram. The treatment plan recommended continuation of symptomatic treatment and work restrictions. The 9/27/14 utilization review denied the request for the right shoulder magnetic resonance arthrogram as there were no clinical exam findings that were suspicious for any anatomical defect including labral or rotator cuff tear.

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

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

#### **1 Right Shoulder Arthrogram: 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, Shoulder (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, MR Arthrogram

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines indicate that magnetic resonance arthrography is generally useful to identify and define shoulder pathology relative to rotator cuff tears, recurrent dislocation, and infection. Routine imaging is not recommended for evaluation of shoulder complaints without surgical indications. In general, guideline criteria for ordering imaging studies include emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, or clarification of the anatomy prior to an invasive procedure. The Official Disability Guidelines state that the magnetic resonance arthrogram is recommended as an option to detect labral tears and for suspected re-tear post-operative rotator cuff repair. If there is any question concerning the distinction between a full-thickness and partial-thickness tear, magnetic resonance arthrography is recommended. The guideline criteria have not been met. The injured worker presents with a reportedly unremarkable right shoulder physical exam with full range of motion and strength. There is no indication of rotator cuff or labral pathology noted on the reported magnetic resonance imaging findings. There are no current surgical indications. Therefore, this request is not medically necessary. The 9/16/14 orthopedic report documented that the injured worker had been released to modified work on 8/18/14 with lifting and overhead work restrictions, with total work limited to 5.5 hours per day. He reported he was unable to handle the hours and requested restrictions be dropped to 4 hours per day. He complained of excruciating shoulder pain. The pain was worse with motion and improved with ibuprofen. He reported associated edema, catching, popping, instability, weakness, and abnormal noises with shoulder motion. The physical exam documented an unremarkable gross exam with no obvious swelling. There was an exaggerated pain response (painful Facies) on palpation of the lateral edge of the acromion and subjective pain with elevation of the arm above shoulder level. The Neer's test was positive and the drop arm test was negative. There was no pain to palpation of the bicipital groove tendon. The range of motion was full when attention was distracted and he able to push off exam table with both arms. The diagnosis was shoulder joint

pain and impingement syndrome. The treating physician discussed the fact that the pain displayed did not necessarily fit the physical findings. The magnetic resonance imaging was reviewed with the radiologist who recommended an arthrogram. The treatment plan recommended continuation of symptomatic treatment and work restrictions. The 9/27/14 utilization review denied the request for the right shoulder magnetic resonance arthrogram as there were no clinical exam findings that were suspicious for any anatomical defect including labral or rotator cuff tear.