

Case Number:	CM14-0111708		
Date Assigned:	08/06/2014	Date of Injury:	09/15/2009
Decision Date:	10/03/2014	UR Denial Date:	07/10/2014
Priority:	Standard	Application Received:	07/17/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 37-year-old male with a 9/15/09 date of injury, and left shoulder arthroscopic subacromial decompression with acromioplasty, posterior Bankart labral repair, and rotator cuff repair on 10/28/11. At the time (6/17/14) of request for authorization for Repeat MR arthrogram left shoulder, there is documentation of subjective complaints of increased left shoulder pain associated with numbness and tingling in the left arm. The objective findings include decreased range of motion, tenderness over the biceps groove and glenohumeral joint, and positive sulcus sign. Imaging findings include MR arthrography of the left shoulder (11/1/12) report revealed no evidence of a tear of rotator cuff and mild posterior subluxation of the left humeral head in relationship to glenoid fossa. Current diagnoses are shoulder pain. Treatment to date includes medications. Medical report identifies that the requested repeat MR arthrogram is to evaluate for anatomic pathology due to the increased left shoulder pain symptoms and instability on physical examination.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat MR arthrogram left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): page 207 - 208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 12th edition (web), 2014 Shoulder Chapter, MR Arthrography

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Arthrography Other Medical Treatment Guidelines: Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging

Decision rationale: MTUS reference to ACOEM guidelines identifies that imaging may be considered for a patient whose limitations due to consistent symptoms have persisted for one month or more; and that magnetic resonance imaging and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy. Official Disability Guidelines (ODG) identifies that subtle tears that are full thickness are best imaged by arthrography and that MR arthrography is usually necessary to diagnose labral tears. In addition, ODG identifies documentation of a diagnosis/condition, with supportive subjective/objective findings, for which a repeat study is indicated, such as to diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings. Imaging of these changes is necessary to determine the efficacy of the therapy or treatment. However, repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment, to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings as criteria necessary to support the medical necessity of a repeat MRA. Within the medical information available for review, there is documentation of a diagnosis of shoulder pain. In addition, there is documentation of a previous left shoulder MRA (11/1/12). The requested for a repeat MR arthrogram is to evaluate for anatomic pathology due to the increased left shoulder pain symptoms and instability. On physical examination, there is documentation of a diagnosis/condition for which a repeat study is indicated (to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for repeat MR arthrogram left shoulder is medically necessary.