

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0111710 | | |
| Date Assigned: | 08/01/2014 | Date of Injury: | 09/15/2009 |
| Decision Date: | 10/02/2014 | UR Denial Date: | 06/27/2014 |
| 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 Physical Medicine & Rehabilitation 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 arthroscopic subacromial decompression with acromioplasty, posterior Bankart labral repair, and rotator cuff repair on 10/28/11. At the time (6/17/14) of the request for authorization for repeat MRI arthrogram, left shoulder, there is documentation of subjective (shoulder pain) and objective (movements are restricted, tenderness is noted in the biceps groove and glenohumeral joint, positive sulcus sign) findings, imaging findings (MRI arthrography of the left shoulder (11/1/12) report revealed post-surgical changes. No evidence of a tear of rotator cuff. There is mild posterior subluxation of the left humeral head in relationship to glenoid fossa), current diagnoses (shoulder pain), and treatment to date (medication, therapy, and TENS unit). There is no 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 and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (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).

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat MRI arthrogram, left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines(ODG), Treatment Index, 12th Edition 9web) 2014, Shoulder-MR Arthrogram and Magnetic resonance imaging (MRI)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208. Decision based on Non-MTUS Citation 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. 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 and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (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 repeat imaging. Within the medical information available for review, there is documentation of diagnoses of shoulder pain. In addition, there is documentation of a previous MRI arthrogram. However, there is no 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 and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (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). Therefore, based on guidelines and a review of the evidence, the request for repeat MRI arthrogram, left shoulder is not medically necessary.