

Case Number:	CM15-0171080		
Date Assigned:	09/11/2015	Date of Injury:	05/18/2011
Decision Date:	10/15/2015	UR Denial Date:	08/19/2015
Priority:	Standard	Application Received:	08/31/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 male, who sustained an industrial-work injury on 5-18-11. He reported initial complaints of right shoulder, elbow, hand, knee, neck, low back and right hip pain status post motor vehicle accident. The injured worker was diagnosed as having trochanteric bursitis, hip joint inflammation, and anxiety. Treatment to date has included medication, steroid injection, psychiatrist consult, and diagnostics. MRI results on 7-28-15 were reported to be negative of the right hip. Currently, the injured worker complains of chronic right hip pain with difficulty with prolonged standing and walking. There was 50% reduction in pain with cortisone injection on 5-22-15. He is currently not working. Per the primary physician's progress report (PR-2) on 8-6-15, exam noted tenderness along right hip with abduction, negative grind test, abduction at 20 degrees on the right compared to 50 degrees on the left. Current plan of care includes an MR arthrogram prior to arthroscopic surgery to rule out labral tear. The Request for Authorization date was 8-6-15 and requested service included MR Arthrogram of the right hip. The Utilization Review on 8-19-15 denied the request due to lack of support for the procedure and therefore not medically necessary, per ODG (Official Disability Guidelines) guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

MR Arthrogram of the right hip: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines ODG.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG online, Hip/Pelvis, Arthrography.

Decision rationale: The patient presents with pain affecting the right hip. The current request is for MR Arthrogram of the right hip. The treating physician report dated 8/6/15 (399C) states, "A recent MRI has been negative; however, it can miss labral tear. As such, we are requesting MR arthrogram prior to arthroscopic surgery for the right hip. He will be contacted once MR arthrogram has been completed." The MTUS guidelines do not address the current request. The ODG guidelines state the following regarding Arthrography: "Recommended for suspected labral tears." In this case, the treating physician is requesting an MR arthrogram in order to rule out a suspected labral tear prior to proceeding with arthroscopic surgery of the right hip. The current request satisfies the ODG guidelines as outlined in the "Hip & Pelvis" chapter. The current request is medically necessary.