

Case Number:	CM13-0059350		
Date Assigned:	12/30/2013	Date of Injury:	03/04/2011
Decision Date:	03/24/2014	UR Denial Date:	11/13/2013
Priority:	Standard	Application Received:	12/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine 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 physician 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 patient is a 68 year old female who was injured on 3/4/2011 she fell out of a chair and hit her right knee on the floor. Since then the patient has developed compensatory pain in the left hip, back pain and bilateral lower extremity pain. Prior treatment history included right knee meniscus repair on 12/19/2011, S1 joint injections, right arthroscopic knee surgery on 1/20/13. Patient also participated in physical therapy and exercised at home as instructed. Medication treatments include cymbalta, trazadone, gabapentin and Celebrex, which helped with her symptoms. An MRI L-spine on 06/01/2012 demonstrated broad based & lateral disc bulge at L3-4 & L4-5, 2-3mm and 1-2mm broad based & lateral disc bulges at L5-S1, mild thecal sac effacement w/o evidence of spinal stenosis, and a transitional S1 vertebral segment. The patient was also noted to have an unremarkable X-ray of the left hip on 08/15/2011. Subsequently, an X-ray of the left hip in 11/2013 demonstrated mild degenerative changes. In a clinic note dated 1/8/14, patient was following up in clinic for worsening back and lower extremity pain in the setting of her medications not being approved. Per the note, patient did not sustain any injury since her last visit. On physical exam, the patient had a right sided push off antalgic gait. Normal appearing spine on inspection. Her range of motion on forward flexion, right lateral flexion and left lateral flexion of the spine was limited by pain. She had positive paravertebral tenderness on palpation. Tenderness was noted over the sacroiliac spine, worse on the left. Tenderness was also noted over the S1 joint and trochanter. Range of motion of the left hip was normal, although patient experienced deep buttock pain on internal rotation of the femur. Gaenslen's and FABER tests were positive. The patient's ankle jerk reflex was $\hat{A}^{1/4}$ on bilaterally and her Patellar reflexes were $\hat{A}^{1/4}$ bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

One x-ray of the left hip: 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), Chapter, Hip & Pelvis

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chapter, Hip & Pelvis (Acute & Chronic), X-Ray

Decision rationale: CA MTUS and ACOEM do not discuss specifically about the request, therefore ODG have been sought. Per the records, the patient was complaining of back and Left hip pain during her clinic visit on October 9, 2013. The patient previously had a hip x-ray on 8/15/11 which was normal. During her 10/9/2013 clinic visit, exam of the left hip demonstrated no erythema, swelling, atrophy, deformity or loss of ROM. She did have positive tenderness over the SI joint and trochanter, and a positive Faber and Gaenslen tests. Repeat hip x-ray was ordered and approved in November 2013, and demonstrated mild degenerative changes. Although the patient complains of worsening back and lower extremity pain in the clinic note dated 1/8/13, she did not endorse any new accidents or falls, and her increased pain was in the setting of not being able to take her medications. Furthermore, her lower back and hip exam on 1/8/14 is identical to the exam documented on 10/09/13, thus objectively verifying that nothing has significantly changed. The provider requested a new x-ray of left hip to evaluate persistent left hip pain. As per the ODG, Plain radiographs of the pelvis should routinely be obtained in patients that sustain a severe injury. X-rays are also useful for identifying patients with a high risk of the development of hip osteoarthritis. Lastly, plain x-rays are also sufficient to diagnose hip fracture with approximately 90% sensitivity. The patient did not sustain any new injury since her last visit, has documented degenerative changes on x-ray performed in November 2013, and has an unchanged physical exam since November as well. It appears that the x-ray might have accidentally been ordered as a duplicate study. There is no indication to repeat the hip x-ray as nothing has objectively changed since November 2013. Thus, the request for one x-rays of the left hip was not a medical necessity and is non-certified.