

<b>Case Number:</b>	CM15-0161208		
<b>Date Assigned:</b>	08/28/2015	<b>Date of Injury:</b>	03/03/2015
<b>Decision Date:</b>	09/30/2015	<b>UR Denial Date:</b>	08/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2015

### 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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 30 year old male who sustained an industrial injury on March 03, 2015. A progress noted dated July 13, 2015 reported subjective complaint of right lower back pain radiating up the upper back and it is very painful. Any use of her back makes the pains worse. Objective assessment found pain with palpation, flexion, extension, and rotation; positive for spasm and deformity. He was diagnosed with back strain. He is to begin using Naprosyn 2-3 times daily. An orthopedic follow up dated June 29, 2015 reported chief subjective complaint of back pain that occurred from an industrial injury described as while working picking up a box over above his head and heard a pop with resulting injury. The pain does radiate into the lower extremities. Treatment to date has included: activity modification, acupuncture therapy, physical therapy; conservative methods. He is temporarily totally disabled. He is not taking oral medications at this time. A magnetic resonance imaging study performed on May 15, 2015 reported normal alignment and disc space. He was diagnosed with benign low back pain. The plan of care noted the most appropriate course of treatment is to utilize proper body mechanics, encouraged to participate in an exercise program and use of occasional anti-inflammatory agents. He is to return to modified work duty for three weeks then back to a full work duty schedule for one week and follow up visit. At follow up on June 03, 2015 he reports doing worse and hurting worse after working two shifts. There is note of a pending orthopedic evaluation determining the next course of action and he will stay off from work for a week. Again on June 17, 2015 at follow up there is noted unchanged still worse with pain and off from work. There is note of a scheduled orthopedic visit for June 29th. There is mention of a pending magnetic resonance

imaging study determining a definite diagnosis for this atypical pain. On June 16, 2015 he underwent a MRI of the lumbar spine showing normal morphologic features, alignment and signal intensity and no anatomical basis for neural impingement is found.

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

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

**X-ray of pelvis:** 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), Hip and Pelvis Chapter, X-ray.

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

**Decision rationale:** MTUS guidelines do not address the use of x-rays of the pelvis specifically. Per the ODG, x-rays of the hip/pelvis are recommended. Plain radiographs (X-Rays) of the pelvis should routinely be obtained in patients sustaining a severe injury. X-Rays are also valuable for identifying patients with a high risk of the development of hip osteoarthritis. Although the diagnostic performance of the imaging techniques (plain radiography, arthrography, and bone scintigraphy) was not significantly different, plain radiography and bone scintigraphy are preferred for the assessment of a femoral component because of their efficacy and lower risk of patient morbidity. X-rays are not as sensitive as CT in detection of subchondral fractures in osteonecrosis of the femoral head. Plain radiographs are usually sufficient for diagnosis of hip fracture as they are at least 90% sensitive. Standard radiographic hip imaging includes antero-posterior (AP) pelvic projection with dedicated AP and cross-table lateral projections of the affected hip. Conventional estimates have put the sensitivity of these projections for hip fracture between 90% and 98%. This study highlights the limitations of radiography in detecting hip or pelvic pathologic findings, including fractures, as well as soft-tissue pathologic findings. MRI shows superior sensitivity in detecting hip and pelvic fractures over plain film radiography. In this case, there is no history of trauma to the pelvis or neurogenic dysfunction of the hip or pelvis. There is no diagnosis that would warrant the need for a pelvis x-ray. The request for X-ray of pelvis is determined to not be medically necessary.