

<b>Case Number:</b>	CM15-0192299		
<b>Date Assigned:</b>	10/06/2015	<b>Date of Injury:</b>	05/16/2015
<b>Decision Date:</b>	11/16/2015	<b>UR Denial Date:</b>	09/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/30/2015

### 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: Montana, Oregon, Idaho  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 54 year old female, who sustained an industrial injury on 5-16-15. The documentation on 8-20-15 noted that the injured worker has complaints of neck and mid back pain and aching pain, burning sensation, stabbing pain, tingling, and numbness down her legs to her big toes. The injured worker has pain in her right leg down to her toes become numb. The injured worker has difficulty standing from a sitting position. The injured worker has difficulty sleeping and the injured worker has relief with rest, activity modification and medications. The injured worker has 7 out of 10 pain at rest, which increases to 9 out of 10 on visual analog scale. There is palpable tenderness and spasm over the right L4-5 region measuring 4 X 3cm and there is minimal tenderness over the right sacroiliac joint. Straight leg raise is positive on the right at 90 degrees, negative on the left at 90 degrees. The diagnoses have included sprain of lumbar; thoracic or lumbosacral neuritis or radiculitis, unspecified and left hip degenerative joint disease. Treatment to date has included physical therapy; injections; naproxen; temazepam for sleep but stopped because it did not help and made her dizzy; ibuprofen upset her stomach; Anaprox; tramadol and Fexmid. The injured worker reports she takes her husband's tramadol for extreme pain. Magnetic resonance imaging (MRI) showed stenosis causing her right leg pain. The documentation in June 2015 the injured worker completed 3 physical therapy sessions that were discontinued due to her experiencing nausea and dizziness after the therapy. The original utilization review (9-14-15) denied the request for X-ray for left hip.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**X-ray for left 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) Hip & Pelvis (updated 08/20/15) Online Version.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pelvis and hip.

**Decision rationale:** A MTUS/ACOEM is silent on the issue of hip plain radiographs. ODG-TWC, pelvis and hip section was therefore consulted. 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, the worker is a 54 year old female with low back and left hip pain. The record documents a history of left hip degenerative joint disease. The clinical note from 8/20/15 documented difficulty from standing to sitting left groin pain with internal and external rotation of the left hip. As there are no prior imaging reports confirming the diagnosis, history and physical exam, findings are suspicious for left hip osteoarthritis. As the guidelines state, "X- Rays are also valuable for identifying patients with a high risk of the development of hip osteoarthritis," this request is medically necessary.