

Case Number:	CM15-0027118		
Date Assigned:	02/19/2015	Date of Injury:	02/18/2013
Decision Date:	04/07/2015	UR Denial Date:	01/16/2015
Priority:	Standard	Application Received:	02/12/2015

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: New York, West Virginia, Pennsylvania
 Certification(s)/Specialty: Emergency 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 52 year old male, who sustained an industrial injury on 2/18/2013. He fell from a rooftop and was held up by a harness. The diagnoses have included cervical facet syndrome, cervical pain, low back pain, and lumbar radiculopathy. Treatment to date has included conservative measures. Currently, the injured worker complains of backache and left knee pain. Pain was rated 5/10 with medications and 7/10 without medications. He appeared anxious and in a moderate amount of pain. Current medications included Celebrex, Robaxin, and Cymbalta. Magnetic resonance imaging of the cervical spine (5/31/2013) was documented as showing C4-5 mild annular bulge, C5-6 minimal annular bulge with mild right uncovertebral and facet hypertrophy and mild right neuroforaminal narrowing, C6-7 minimal spinal canal narrowing with mild bilateral neural foraminal narrowing. Magnetic resonance imaging of the lumbar spine (3/01/2013) was documented as showing disc degeneration at L4-5, L5-S1, minimal facet arthropathy at L5-S1, disc bulge and spur, without definite neuropathic impingement, and tiny annular tear at L4, without neuropathic impingement. Restricted range of motion was noted to the cervical and lumbar spines. Tenderness was noted over the sacroiliac spine. Straight leg raise test was positive on the left side in sitting at 90 degrees. Motor exam noted hip flexor 5/5 on both sides. Decreased sensation was noted over the lateral foot and anterior thigh, posterior thigh on the left side. Recommendations included a request for bilateral hips/pelvis to rule out avascular necrosis. On 1/16/2015, Utilization Review non-certified a request for magnetic resonance imaging of the left hip/pelvis, without contrast. Referenced guidelines were not specified.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the left hip and pelvis without contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 303-304.

Decision rationale: Guidelines recommend MRI of the hip for osseous, articular or soft tissue abnormalities, osteonecrosis, occult acute and stress fracture, acute and chronic soft tissue injuries, or tumors. In this case, clinical documents provided do not detail objective physical examination findings for the hip and details regarding the need for an MRI of the hip are lacking. Thus, the request for MRI of the hip is not medically appropriate and necessary.