Case Number:	CM15-0052629		
Date Assigned:	03/26/2015	**Date of Injury:**	02/27/2013
Decision Date:	05/04/2015	**UR Denial Date:**	02/19/2015
Priority:	Standard	**Application Received:**	03/19/2015

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 Jersey, Michigan, California
Certification(s)/Specialty: Neurology, Neuromuscular 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 46 year old male, who sustained an industrial injury on 2/27/2013. The medical records submitted for this review did not include the details regarding the initial injury. Diagnoses include lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, and L1 compression fracture, bilateral carpal tunnel syndrome, status post left side carpal tunnel release 3/12/14. Treatments to date include medication therapy, orthotic brace, activity modification, physical therapy and steroid injections. Currently, they complained of pain rated 9/10 VAS in the lumbar spine. On 2/2/15, the physical examination documented diffuse tenderness over lumbar spine and severe facet tenderness at L4. There was sacroiliac tenderness with positive Fabere's, sacroiliac thrust, and yeoman's tests. The straight leg raise test was positive bilaterally. The provider documented CT findings including sclerotic changes in the right iliac crest. The plan of care included MRI of the right iliac crest.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right iliac crest: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, Lumbar & Thoracic, MRIs (magnetic resonance imaging).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MRI (magnetic resonance imaging). http://www.odg-twc.com/index.html.

Decision rationale: According to ODG guidelines, pelvic MRI "Recommended as indicated below. MRI is the most accepted form of imaging for finding a vascular necrosis of the hip and osteonecrosis. (Koo, 1995) (Coombs, 1994) (Cherian, 2003) (Radke, 2003) MRI is both highly sensitive and specific for the detection of many abnormalities involving the hip or surrounding soft tissues and should in general be the first imaging technique employed following plain films. (American, 2003) (Chana, 2005) (Brigham, 2003) (Stevens, 2003) (Colorado, 2001) (Wild, 2002) (Verhaegen, 1999) (Scheiber, 1999) (Helenius, 2006) (Sakai, 2008) (Leunig, 2004) (Armfield, 2006) (Bredella, 2005) MRI seems to be the modality of choice for the next step after plain radiographs in evaluation of select patients with an occult hip fracture in whom plain radiographs are negative and suspicion is high for occult fracture. This imaging is highly sensitive and specific for hip fracture. Even if fracture is not revealed, other pathology responsible for the patient's symptoms may be detected, which will direct treatment plans. (Cannon, 2009) (Nelson, 2005) However, MRI of asymptomatic participants with no history of pain, injury, or surgery revealed abnormalities in 73% of hips, with labral tears being identified in 69% of the joints. (Register, 2012) 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. (Kirby, 2010) While both MRI (0.5-3T) and MRA (0.5-3T) have moderate sensitivity and specificity (sensitivity 66%, 87%; specificity 79%, 64%), diagnostic accuracy of MRA appears to be superior to MRI in detecting acetabular labral tears on ROC curve interpretation. When magnetic resonance magnet strength was restricted to 1.5-T, the pooled sensitivity for MRI was 70% and the pooled specificity was 82%. The pooled sensitivity for MRA was 83% and the pooled specificity was 57%. (Smith, 2011) However, recent reports have shown similar accuracy when MRA is compared with MRI when an optimized hip protocol and 3.0-T magnets are used. (Register, 2012) (Sundberg, 2006) Indications for imaging Magnetic resonance imaging: Osseous, articular or soft-tissue abnormalities Osteonecrosis Occult acute and stress fracture; Acute and chronic soft-tissue injuries Tumors Exceptions for MRI Suspected osteoid osteoma. (See CT) Labral tears (use MR arthrography unless optimized hip protocol and MRI with 3.0-T magnets)." There is no documentation of suspicion of pelvic fracture, tumor or pelvic osteonecrosis. Therefore, the request is not medically necessary.