

Case Number:	CM15-0174292		
Date Assigned:	09/16/2015	Date of Injury:	10/01/2007
Decision Date:	10/23/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	09/04/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 was a 58 year old female, who sustained an industrial injury, October 1, 2007. The injured was from a trip and fall. According to progress note of July 23, 2015, the injured worker's chief complaint was hand numbness and cervical spine pain and spasms. The range of motion was 60%. There were no acute neurological changes. There was no gross instability. The over lining skin looked good. There was 60% range of motion to the right hand. There was positive numbness and positive Tinel's and Phalen's. The injured worker was undergoing treatment for cervical, thoracic, lumbar and sacral spine with bilateral radicular pain, right greater than the left, bilateral sciatica, right shoulder sprain and or contusion with possible internal derangement, right wrist sprain and or contusion possible internal derangement, chronic pain and lumbar stability. The injured worker previously received the following treatments Skelaxin, Relafen, Tylenol, Voltaren, Lidocaine Patches and discectomy in 2008. The RFA (request for authorization) dated the following treatments were requested MRIs of the bilateral hips and pelvis. The UR (utilization review board) denied certification on August 11, 2015: for the basis of the review of the medical records provided was the proposed treatment consisting of MRI of the bilateral hips and pelvis were not appropriate or medically necessary for the diagnosis and clinical findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Bilateral Hips/Pelvis: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG online Version 2015, Hip Chapter, MRI.

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, MRI.

Decision rationale: Per the ODG guidelines: Recommended as indicated below. MRI is the most accepted form of imaging for finding avascular 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). The documentation submitted for review contains no evidence of plain film radiographs, or any indication for the request. The request is not medically necessary.