

Case Number:	CM15-0179447		
Date Assigned:	09/21/2015	Date of Injury:	07/01/2015
Decision Date:	10/26/2015	UR Denial Date:	08/15/2015
Priority:	Standard	Application Received:	09/11/2015

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 28 year old male, who sustained an industrial injury on 7-1-15. The injured worker was diagnosed as having lumbar paraspinal muscle strain; hip joint pain; right knee joint pain; right and left foot contusion; right and left foot muscle strain. Treatment to date has included physical therapy; medications. Diagnostics studies included X-ray lumbar spine (7-5-15); X-rays bilateral feet (7-5-15); X-ray right hip (7-9-15); X-rays right knee (7-9-15). Currently, the PR-2 notes dated 7-23-15 indicated the injured worker complains of pain "bilateral ankle-foot pain and discomfort". The "Doctor's First Report of Occupational Injury or Illness" dated 7-1-15 reported the injured worker reported he has a fall from a second story and landed on his bilateral feet and then a heavy panel fell onto his left side. The provider documents the same injury. He was seen by a trauma team at a medical center and he reports he had many CT scans (head and hips) and x-rays and was discharged with Tylenol after a night of observation. There are no CT scan reports submitted. X-rays of the lumbar spine on 7-5-15 impression reveals: "Vertebral bodies are normal in height and alignment. There is no evidence of fracture or malalignment. No significant degenerative changes notes. Intervertebral disc spaces are well preserved, symmetric and maintained. No soft tissue abnormality is identified." X-rays of bilateral feet dated 7-5-15 impression reveal "1) No evidence of fracture or dislocation in the bilateral feet. 2) Moderate right calcaneal spur." X-ray report of right hip on 7-9-15 impression reveals "No acute fracture is identified. The alignment is normal. No significant joint disease is noted. No significant soft tissue abnormality is identified." X-ray of the right knee reports on 7-9-15 impression: "no acute fracture or dislocation of the knee joint is identified. The alignment is normal. No significant joint disease is noted. No significant soft tissue abnormality is identified." The provider documents subjective complaints: "Patient has minimal foot pain at rest. With walking, he feels sharp severe pain in bottom of heel of both feet that

worsens with walking and resolves with sitting. He has no swelling or bruising. No numbness. Able to fully weight bear. He has mild low back pain at rest, mild to moderate with bending and lifting, reduces with rest, radiates to the right hip area. He has sharp occasional right knee and hip pain with walking, no pain at rest, positive weakness, no numbness in the legs. He has sharp intermittent left knee pain now, just started the last few weeks, with walking. No GU changes. On physical examination, the provider documents: "right hip-He exhibits decreased range of motion and decreased strength. He exhibits no tenderness, no bony tenderness and no swelling. Right knee: He exhibits decreased range of motion (slight loss extension) and abnormal meniscus. He exhibits no swelling, no effusion, no deformity, normal alignment, no LCL laxity, normal patellar mobility, no bony tenderness and no MCL laxity. Tenderness found. Medial joint line and lateral joint line tenderness noted. No MCL, no LCL and no patellar tendon tenderness noted. Left Knee: He exhibits decreased range of motion (slight loss extension) and abnormal meniscus. He exhibits no swelling, no effusion, no ecchymosis, no LCL laxity, normal patellar mobility, no bony tenderness and no MCL laxity. Tenderness (tender posterior knee) found. Right ankle: He exhibits normal range of motion, no swelling, no ecchymosis, and no deformity. No tenderness. No lateral malleolus, no medial malleolus, not AITFL, no posterior TFL, no head of 5th metatarsal and no proximal fibula tenderness found. Achilles' tendon normal. Left Ankle: He exhibits normal range of motion. Lumbar back: He exhibits decreased range of motion, tenderness, pain and spasm. Right upper leg and Right lower leg: He exhibits no tenderness, no bony tenderness and no swelling. Right foot: There is tenderness. There is normal range of motion, no bony tenderness, no swelling and normal capillary refill. Left foot: There is tenderness. There is normal range of motion. Neurological: He is alert and oriented to person, place and time. He has normal sensation and normal reflexes. He displays weakness. No sensory deficit. He has normal Straight Leg Raise test. Gait abnormal." The provider's treatment plan included a request for MRI, podiatry appointment, light exercise, use ice-heat and ointments, Norco 5-325mg and discontinue Percocet. A Request for Authorization is dated 8-25-15. A Utilization Review letter is dated 8-15-15 and non-certification was for MRI of right hip without contrast. Utilization Review denied the requested treatment for not meeting the ODG Guidelines. The provider is requesting authorization of MRI of right hip without contrast.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of right hip without contrast: 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, 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 Chapter/MRI (magnetic resonance imaging) Section.

Decision rationale: MTUS guidelines do not address the use of MRI for the hip. Per the ODG, MRI is the most accepted form of imaging for finding avascular necrosis of the hip and osteonecrosis. 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. 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. 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. In this case, there is no evidence of plain films of the right hip. There is also no documented instability of the hip or pain. The request for MRI of right hip without contrast is determined to not be medically necessary.