

<b>Case Number:</b>	CM13-0029072		
<b>Date Assigned:</b>	11/27/2013	<b>Date of Injury:</b>	08/28/2007
<b>Decision Date:</b>	05/21/2014	<b>UR Denial Date:</b>	08/28/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2013

### 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. The expert reviewer is Board Certified in Neurology, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 57 year old man who sustained a work-related injury on August 28, 2007. Subsequently he developed chronic back pain and right hip pain. The patient underwent L4-L5 discectomy on 2007 and 2008. He also underwent L4-L5 fusion in 2008. According to the note dated on August 8, 2013, the patient was complaining of right low back pain and right buttock pain with right leg numbness and tingling as well as right hip pain. His physical examination demonstrated a right lumbar tenderness with reduced range of motion. There was a positive piriform tightness test. The patient was treated with physical therapy, Celexa, aspirin 80, ibuprofen and Advil. The provider requested authorization for piriformis injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **DIAGNOSTIC PIRIFORMIS MUSCLE INJECTION WITH LOCAL ANESTHETIC AND STEROIDS TO THE R HIP:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Comp., online Edition Chapter: Low Back

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) section on Piriformis injections, <http://www.worklossdatainstitute.verioiponly.com/odgtwc/hip.htm>

**Decision rationale:** According to the ODG regarding Piriformis injections, "Recommended for piriformis syndrome after a one-month physical therapy trial. Piriformis syndrome is a common cause of low back pain and accounts for 6-8% of patients presenting with buttock pain, which may variably be associated with sciatica, due to a compression of the sciatic nerve by the piriformis muscle (behind the hip joint). Piriformis syndrome is primarily caused by fall injury, but other causes are possible, including pyomyositis, dystonia musculorum deformans, and fibrosis after deep injections. Symptoms include buttock pain and tenderness with or without electrodiagnostic or neurologic signs. Pain is exacerbated in prolonged sitting. Specific physical findings are tenderness in the sciatic notch and buttock pain in flexion, adduction, and internal rotation (FADIR) of the hip. Imaging modalities are rarely helpful, but electrophysiologic studies should confirm the diagnosis, if not immediately, then certainly in a patient re-evaluation and as such should be sought persistently. Physical therapy aims at stretching the muscle and reducing the vicious cycle of pain and spasm. It is a mainstay of conservative treatment, usually enhanced by local injections. Surgery should be reserved as a last resort in case of failure of all conservative modalities. No consensus exists on overall treatment of piriformis syndrome due to lack of objective clinical trials. Conservative treatment (eg, stretching, manual techniques, injections, activity modifications, modalities like heat or ultrasound, natural healing) is successful in most cases. For conservative measures to be effective, the patient must be educated with an aggressive home-based stretching program to maintain piriformis muscle flexibility. He or she must comply with the program even beyond the point of discontinuation of formal medical treatment. Injection therapy can be incorporated if the situation is refractory to the aforementioned treatment program. Injections with steroids, local anesthetics, and Botulinum toxin have been reported in the literature for management of this condition, but no single technique is universally accepted. Localization techniques include manual localization of muscle with fluoroscopic and electromyographic guidance, or ultrasound. The piriformis muscle, after localization with a digital rectal examination, can be injected with a spinal needle. Care should be taken to avoid direct injection of the sciatic nerve. (Papadopoulos, 2004) (Kuncewicz, 2006) (Huerto, 2007) See also Psoas blocks." In the medical records provided for review, there is no clinical and electrophysiological documentation supporting a piriform syndrome. There is also no documentation of response to prior physical therapy. Therefore, the request for piriformis muscle injection with local anesthetic and steroids to the right hip is not medically necessary and appropriate.