

<b>Case Number:</b>	CM13-0037269		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	02/02/2009
<b>Decision Date:</b>	02/28/2014	<b>UR Denial Date:</b>	09/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/27/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and Sports 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 physician 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:

The patient is a 46-year-old female who reported an injury on 02/02/2009. The patient is currently diagnosed with degeneration of intervertebral disc, displacement of intervertebral disc without myelopathy, lumbar sprain, enthesopathy of hip region, and lumbar postlaminectomy syndrome. [REDACTED] saw the patient on 08/20/2013. The patient presented with ongoing left hip pain. Physical examination revealed decreased flexion and extension of the lumbar spine, 5/5 motor strength throughout, decreased sensation on the lateral leg and dorsum of the foot in the L5 distribution, decreased sensation at the sole of the foot and posterior leg in the S1 distribution, and positive straight leg raising on the left. The patient was administered an ultrasound guided left greater trochanteric bursa hip steroid injection. Treatment recommendations included continuation of current medications and 4 to 6 physical therapy visits for the left hip

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ultrasound guided IT band injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://emedicine.medscape.com/article/91129-treatment>

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis Chapter, Trochanteric bursitis injections

**Decision rationale:** The Physician Reviewer's decision rationale: California MTUS/ACOEM Practice Guidelines state invasive techniques such as local injections are of questionable merit. Official Disability Guidelines state trochanteric bursitis injections are recommended. For trochanteric pain, a corticosteroid injection is safe and highly effective with a single corticosteroid injection often providing satisfactory pain relief. As per the clinical documentation submitted, there was no indication of IT band pathology upon physical examination. There was also no evidence of a recent failure to respond to conservative treatment prior to the administration of an ultrasound guided trochanteric bursa hip injection. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

**physical therapy 4-6 sessions:** 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 & Pelvis Chapter, Physical Therapy

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, Physical Therapy

**Decision rationale:** The Physician Reviewer's decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. Official Disability Guidelines state post injection treatment for hip arthropathy includes 1 to 2 visits over 1 week. The current request would exceed guideline recommendations for a total duration of treatment. Therefore, the request is non-certified.

**Flector patches:** 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), Pain chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** The Physician Reviewer's decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials

of antidepressants and anticonvulsants have failed. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. There is no change to the patient's physical examination that would indicate functional improvement. Additionally, there is no evidence of a failure to respond to first line oral medication prior to initiation of a topical analgesic. Based on the clinical information received, the request is non-certified.