Case Number:	CM13-0047319		
Date Assigned:	12/27/2013	**Date of Injury:**	04/10/2012
Decision Date:	03/07/2014	**UR Denial Date:**	10/14/2013
Priority:	Standard	**Application Received:**	11/01/2013

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 Occupational 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 53-year-old male with date of injury 04/10/2012. His primary treating physician is currently [redacted]. [redacted] most recent note for review is dated 11/13/2013. On that date [redacted] listed the patient's diagnoses as, 1. Left lumbar radicular symptoms, 2. L4-5 and L5-S1 degenerative disc disease and 3. Left hip and thigh pain, possible intra-articular pathology that would be a nonindustrial. [redacted] interval history is as follows. Since I last saw [redacted], my request for a diagnostic intra-articular left hip injection was denied. He still has the same pain in the back, mostly on the left side. It radiates across to the right. He also has radiating pain down the left leg and left thigh. He has been able to continue working with restricted duties. Handicapped parking placard was given on last visit, and that helps so that he does not have to walk long distances in the parking lot. Necynta also helps to manage symptoms on daily basis. He does not take any blood thinners. Physical examination was as follows he is a note acute distress well-seated. He can stand and transfer with some difficulty. There is significant tenderness to palpation of the left lumbosacral junction and less of the right. Facet stress maneuver is positive to the left. Strength shows no focal deficits. Hip flexion with internal rotation produces thigh pain. [redacted] states that the patient has reached the point of maximum medical improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic intra-articular left hip injection with fluoroscopic guidance: 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).

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 (Acute & Chronic), Intra-articular steroid hip injection (IASHI).

Decision rationale: The patient's primary treating physician has declared his left hip complaints to be nonindustrial in nature. In addition, the ODG do not recommend the procedure in this instance. Not recommended in early hip osteoarthritis (OA). Under study for moderately advanced or severe hip OA, but if used, should be in conjunction with fluoroscopic guidance. Recommended as an option for short-term pain relief in hip trochanteric bursitis. (Brinks, 2011) Intraarticular glucocorticoid injection with or without elimination of weight-bearing does not reduce the need for total hip arthroplasty in patients with rapidly destructive hip osteoarthritis. (Villoutreix, 2005) A survey of expert opinions showed that substantial numbers of surgeons felt that IASHI was not therapeutically helpful, may accelerate arthritis progression or may cause increased infectious complications after subsequent total hip arthroplasty. (Kasper, 2005) Historically, using steroids to treat hip OA did not seem to work very well, at least not as well as in the knee. However, the hip joint is one of the most difficult joints in the body to inject accurately, and entry of the therapeutic agent into the synovial space cannot be ensured without fluoroscopic guidance. Fluoroscopically guided steroid injection may be effective. (Lambert, 2007) Corticosteroid injections are effective for greater trochanteric pain syndrome (GTPS) managed in primary care, according to a recent RCT. GTPS, also known as trochanteric bursitis, is a common cause of hip pain. In this first randomized controlled trial assessing the effectiveness of corticosteroid injections vs. usual care in GTPS, a clinically relevant effect was shown at a 3-month follow-up visit for recovery and for pain at rest and with activity, but at a 12-month follow-up visit, the differences in outcome were no longer present. (Brinks, 2011) See also Sacroiliac joint blocks; Sacroiliac joint radiofrequency neurotomy; Trochanteric bursitis injections; & Intra-articular growth hormone (IAGH) injection.