

<b>Case Number:</b>	CM13-0068429		
<b>Date Assigned:</b>	05/07/2014	<b>Date of Injury:</b>	04/15/1996
<b>Decision Date:</b>	06/12/2014	<b>UR Denial Date:</b>	11/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2013

### 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 Internal and Emergency Medicine and is licensed to practice in Florida. 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 patient is a 50 year-old with a date of injury of 04/15/96. A progress report associated with the request for services, dated 11/01/13, identified subjective complaints of shoulder, upper back, and neck pain. Overall function is listed as worse, though better with medications. Objective findings included normal range-of-motion of the cervical spine without pain. Sensation was normal and reflexes were symmetric. Diagnoses included myositis; myalgia; fibromyositis; ulnar neuropathy; and carpal tunnel syndrome. Treatment has included oral opioids and anti-seizure agents and home exercises.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**BILATERAL TROCHANTERIC INJECTIONS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip and Pelvis Chapter, Injection Section.

**Decision rationale:** The Medical Treatment Utilization Schedule (MTUS) does not address trochanteric injections. The Official Disability Guidelines (ODG) state that trochanteric bursitis injections are recommended. Also that steroid injection should be offered as a first-time

treatment of trochanteric bursitis, particularly in older adults. In the first randomized trial comparing injection to usual care, a clinically relevant effect if injection was shown at a 3-month follow-up visit for pain at rest and activity, but at a 12-month visit, the differences in outcome were no longer present. There are no recommendations for interval injections. In this case, there were no signs or symptoms documented that would support the medical necessity for a trochanteric injection.