

<b>Case Number:</b>	CM14-0007289		
<b>Date Assigned:</b>	02/10/2014	<b>Date of Injury:</b>	05/15/2012
<b>Decision Date:</b>	06/23/2014	<b>UR Denial Date:</b>	01/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/20/2014

### 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 Physical Medicine and Rehabilitation and Pain Management, has a subspecialty in Interventional Spine 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:

The patient is a 48-year-old male with date of injury of 05/15/2012. The listed diagnoses per [REDACTED], dated 12/17/2013, are: 1. Lumbar facet pain - stable. 2. Left piriformis syndrome. According to the report, the patient complains of left lower back pain that is radiating to the right side. The patient also reports loss of strength in the left lower leg from the knee to the ankle with burning to the left buttock. He also reports minor return of low back pain following radiofrequency from February 2013. Prolonged sitting is tolerated poorly. The physical examination shows lumbar range of motion is minimal with lumbar discomfort upon extension and rotation. The sacroiliac joint is non-tender. There is tenderness on the left piriformis muscle and left greater trochanter muscle. Straight leg raise is negative. Motor exam is 5/5. Deep tendon reflexes bilaterally are equal and within normal limits. Sensory exam is normal. The utilization review denied the request on 01/07/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **LEFT PIRIFORMIS INJECTION: 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) on Trochanteric Bursitis Injections.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG on Trochanteric Bursitis Injections

**Decision rationale:** This patient presents with low back pain with loss of strength to the left lower extremity. The treating physician is requesting a left piriformis injection. The MTUS and ACOEM guidelines do not address this request. However, ODG guidelines on piriformis muscle injection recommends this procedure after a one-month physical therapy trial. Additionally, piriformis syndrome is a common cause of low back pain and accounts for 68% of the patients presenting with buttock pain, which may variably be associated with sciatica. ODG guidelines further require for a diagnosis of piriformis muscle syndrome, buttock pain with examination findings showing pain with flexion, adduction and internal rotation of the hip (FADIR). In this patient, while the patient presents with buttock pain, FADIR has not been documented. There is also lack of documentation that the patient has had therapy specific to piriformis muscle syndrome. The request is not medically necessary and appropriate.

**LEFT GREATER TROCHANTER INJECTION:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -on Trochanteric Bursitis Injections

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - on Trochanteric bursitis injections

**Decision rationale:** This patient presents with low back pain with loss of strength to the left lower extremity. The treater is requesting a left greater trochanter injection. The MTUS and ACOEM guidelines do not address this request. However, ODG guidelines on Trochanteric Bursitis states, "Recommended. Gluteus medius tendinosis/tears and trochanteric bursitis/pain are symptoms that are often related, and commonly correspond with shoulder tendinoses and subacromial bursitis, though there is no evidence of a direct correlation between the hip and shoulder. All of these disorders are associated with hip pain and morbidity. For trochanteric pain, corticosteroid injection is safe and highly effective, with a single corticosteroid injection often providing satisfactory pain relief." The progress report dated 12/17/2013 notes, "Positive tenderness in the left piriformis muscle and the left greater trochanter." Recommendation is for authorization.