

Case Number:	CM14-0190816		
Date Assigned:	11/24/2014	Date of Injury:	03/17/2006
Decision Date:	01/09/2015	UR Denial Date:	10/23/2014
Priority:	Standard	Application Received:	11/15/2014

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, 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 49 year old female with an injury date on 03/17/2006. Based on the 09/29/2014 progress report provided by the treating physician, the diagnoses are: 1. Post Lumbar Laminect Syndrome, 2. Low Back Pain h/o symptomatic sacral Tarlov cysts right inguinal area pain or referred pain (Right). According to this report, the patient complains of "back pain radiating from low back down right leg and right hip pain." Pain is rated as a 6/10 with medications and a 9/10 without medications as 9/10. Physical exam reveals tenderness at the lumbar paravertebral muscles. Motor strength of EHL is 4/5 on right. Deep tendon reflexes of the right knee is 1/4, left knee is 2/4, and bilateral ankle is 1/4. Range of motion of the lumbar spine is restricted. "TTP over right trochanter." There were no other significant findings noted on this report. The utilization review denied the request for right trochanter injection on 10/23/2014 based on the ODG guidelines. The requesting physician provided treatment reports from 05/05/2014 to 11/03/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right 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, Hip and Pelvis

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) hip chapter for trochanteric bursa injections

Decision rationale: According to the 09/29/2014 report, this patient presents with "back pain radiating from low back down right leg and right hip pain." Per this report, the current request is for right trochanter injection "which has been increased after work and prolonged sitting." Regarding trochanteric bursa injections, ODG guidelines state "Recommended... For trochanteric pain, corticosteroid injection is safe and highly effective, with a single corticosteroid injection often providing satisfactory pain relief (level of evidence, C)." Review of report, show no evidence of prior trochanteric bursa injections. The treating physician states that the patient's "right hip has been in increased pain for the most [past] month, she notes that it has worsened with work." Pain "feels like a stabbing pain located along her hip and thigh." Given the patient's hip symptomology a diagnostic trochanteric bursa injection is within ODG guidelines. The request is medically necessary.