MAXIMUS Federal Services

Case Number:	CM14-0191252		
Date Assigned:	11/25/2014	Date of Injury:	09/09/2013
Decision Date:	01/09/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	11/17/2014

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 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 52-year old female with date of injury 9/9/13. The treating physician report dated 10/6/14 (page 15) indicates that the patient presents with pain affecting the right hip despite a trochanteric cortisone injection on 9/29/14, indicating there was no improvement. The patient complains of difficulty walking and sitting. A bilateral hip ultrasound report dated 6/25/14 reveals right great trochanteric bursitis, right gluteus medius tendinosis, right tensor fascia lata strain/microtears/figrosis, with the left hip as normal. A right hip examination reveals tenderness to palpation of the piriformis, gluteus medius, and greater trochanter. There is a positive Faber test. The patient complains of left thumb triggering. The pain level is rated at 6-8/10 and remains unchanged. The left thumb examination reveals tenderness to palpation of the thenar eminence, first CMC joints and extensor compartment. There is A1 pulley active triggering. The patient is temporarily and totally disabled. The current diagnoses are: - Right hip - trochanteric tendinitis and bursitis- Left thumb sprain, contusion, trigger thumbThe utilization review report dated 11/5/14 denied the request for Shock wave therapy x 3 for the right hip based on the ODG. The utilization review report dated 11/5/14 additionally modified the request for Left Thumb Trigger Point Injection under ultrasound guidance to a certification of Left Thumb Trigger Injection only, without ultrasound guidance based on the ODG: Forearm, Wrist and Hand Chapter.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shock wave therapy x 3 for the right hip: Upheld

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 Other Medical Treatment Guideline or Medical Evidence: <National Institute for Health and Care Excellence (NICE)> <Section: Extracorporeal shockwave therapy for refractory greater trochanteric pain syndrome>

Decision rationale: The MTUS Guidelines do not address ESWT. The ODG Guidelines indicate that ESWT is an option for calcifying tendonitis of the shoulder only and is not recommended for treatment of the elbow. The Hip and Pelvis chapter does not address ESWT. The National Institute for Health and Care Excellence (NICE) references extracorporeal shockwave therapy for refractory greater trochanteric pain syndrome. They indicate "evidence on the efficacy and safety of extracorporeal shockwave therapy (ESWT) for refractory greater trochanteric pain syndrome is limited in quality and quantity. Therefore this procedure should only be used with special arrangements for clinical governance, consent and audit or research". In this case the treating physician has not documented any special arrangements for clinical governance, consent and audit or research. In addition, there is no support for a series of 3 treatments. The request is not medically necessary.

Trigger point injection to left thumb: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

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

Decision rationale: The ODG states, "There is good evidence strongly supporting the use of local corticosteroid injections in the trigger finger". In this case the treating physician has documented sufficient need for the Left Thumb Trigger Finger Injection. There is no mention of taut bands on palpation. There is insufficient documentation of trigger points to warrant a trigger point injection. The request is not medically necessary.