

Case Number:	CM14-0196927		
Date Assigned:	12/04/2014	Date of Injury:	11/04/2011
Decision Date:	01/22/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/24/2014

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 Rehab 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 injured worker is a 65-year-old female, with a reported date of injury of 11/04/2011. The mechanism of injury was a fall, after tripping on an uneven carpet. She hit the floor on the right side, striking her right hip and right shoulder. The injured worker indicated that the pain radiated through both hips and her shoulder. The results of the injury were low back pain, left hip pain, and insomnia due to pain. The current diagnosis includes lumbar spondylosis, trochanter bursitis, hip sprain, myofascial pain syndrome, and lumbar sprain/strain. The past diagnosis includes lumbar sprain/strain, right ankle sprain/strain, and right shoulder sprain/strain. The treatments have included physical therapy of the right ankle; TENS stimulation, which did not help; epidural injection, which did help; Voltaren gel, Aleve, and Ultram. The injured worker received approval for a pain management consultation for the left hip and lower extremity. The initial pain management consultation report dated 09/15/2014 indicates that the injured worker complained of low back pain and hip pain. The left lateral thigh pain was constant and worsened with movement and walking. It was noted that the one year after the injury, the left hip became a problem after an Achilles tendon injury had to be casted. The injured worker credits her left-sided symptoms to a change in her gait. An examination of the left hip showed tenderness of the adductor, quadriceps, and medial hamstring muscles; tenderness of the greater trochanter; normal internal rotation; and limited external rotation, flexion, extension, and abduction due to pain. The treating physician did not indicate the reason for recommending the steroid injection of the greater trochanteric bursa. On 10/30/2014, Utilization Review (UR) denied the request for a steroid injection to the left greater trochanteric bursa. The UR physician noted that there was a lack of a comprehensive evaluation with a recent full examination of the left hip and need for injection. The UR physician cited that Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Steroid injection to the left greater trochanteric bursa: 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), Hip and Pelvis, 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) Online Hip and Pelvis Chapter, Trochanteric Bursitis injections Section

Decision rationale: The patient presents with hip and shoulder pain. The current request is for Steroid injection to the left greater trochanteric bursa. The MTUS guidelines do not address trochanteric bursitis injections. The ODG guidelines recommend trochanteric bursitis injections and state, "For trochanteric pain, corticosteroid injection is safe and highly effective, with a single corticosteroid injection often providing satisfactory pain relief." In this case, the physician has diagnosed the patient with trochanteric bursitis and the patient has tenderness affecting the greater trochanter. The current request is supported by the ODG guidelines and is medically necessary. Recommendation is for authorization.