MAXIMUS Federal Services

| Case Number: | CM14-0063805 | | |
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| Date Assigned: | 09/03/2014 | Date of Injury: | 11/01/2006 |
| Decision Date: | 03/03/2015 | UR Denial Date: | 04/21/2014 |
| Priority: | Standard | Application Received: | 05/06/2014 |

## 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Internal Medicine

## 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 was a 51 year old female, who was injured on the job, November 1, 2006. The injured worker sustained injuries to the back, right hip and right knee. The injured worker was pushing a stack of boxes and fell. The injured worker did not receive medical treatment until December 15, 2006. X-rays were taken at that time of the right knee. The injured worker attended physical therapy with no improvement. The injured worker was taken out of work and returned May of 2007 after a right hip pinning in February of 2007. The progress note of November 6, 2013, was an evaluation for pin removal from the right hip. The injured worker was having shooting pains from the right hip through the pelvis and into the left hip. The injured worker's activities of daily living were seriously affected, due to the continuous pain. The pain and stiffness were causing the right hip to lock-up. The injured worker had constipation issues with pain medication. The physical exam of the lumbar spine and lower extremities noted normal heel to toe walking, right hip extension 30 degrees, flexion 130 degrees, external rotation 60 degrees with minima; pain, internal rotation 35 degrees with minimal pain and abduction 45 degrees. The x-ray of the right hip showed 3 well positioned screws and no osteoarthritis. The MRI of the right hip completed August 31, 2013, showed osteoarthritic changes in both hips, enlarged nodes with in the right groin and mild bilateral hamstring tendinosis. Recommendations at that time were not to remove hardware from the right hip and the injured worker to return to work without restrictions. The injured worker was taken out of worker, on December 12, 2013, for a back flare-up. The progress note of January 17, 2014, the injured worker was complaining of pain in the lower paravertebral muscles with right lower muscle spasms. The physical exam of

the lumbar spine noted flexion of 20 degrees, right lateral bending of 20 degrees, left lateral bending of 20 degrees, right lateral rotation of 20 degrees, left lateral rotation of 20 degrees and extension of 10 degrees. Straight leg raising and rectus femoris stretch sign do not demonstrate any nerve irritability. The progress note of March 6, 2014, discusses the possibility of lumbar epidural injection and to discuss the possibility of lumbar spinal surgery. The injured workers current diagnosis were status post ORIF of the right hip, lumbar disc protrusion of L2-23, L3-4, L4-5 and L5-S1 with grade 1 spondylolisthesis at L4-L5 and lumbar radiculopathy. The progress note of April 10, 2014, the injured worker was reporting radicular pain in her legs bilaterally. The aggravating factors were heat, rest sitting, cold lying down, standing, massage, activity, quite, walking, and bowel movements. Alleviating factors was medication. Recommendations were lumbar epidural steroid injection and intra articular injection. The injected worker had not had injections in the past for pain control. The documentation submitted for review did not include radiology reports, documented medication effectiveness or other conservative treatment documentation. The injured worker has not worked since June 14, 2013. On April 21, 2014 the Ur denied a right hip intra-articular injection. The Bases for the denial was the OGD guidelines Chapter on Hip and Pelvis; Intra-articular steroid injection was not recommended in early hip osteoarthritis.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Hip Intra- Articular 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 - Treatment for Workers' Compensation, Online Edition; Chapter: Hip and Pelvis (Acute & Chronic) ; Intra-articular steroid hip Injection (IASHI)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Hip & Pelvis (Acute & Chronic)

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) does not address intra-articular hip injection. Official Disability Guidelines (ODG) Hip & Pelvis (Acute & Chronic) indicates that intra-articular steroid hip injection is not recommended in early hip osteoarthritis, and is under study for moderately advanced or severe hip osteoarthritis. Intraarticular glucocorticoid injection does not reduce the need for total hip arthroplasty in patients with rapidly destructive hip osteoarthritis. A survey of expert opinions showed that substantial numbers of surgeons felt that intraarticular glucocorticoid injection was not therapeutically helpful, may accelerate arthritis progression or may cause increased infectious complications after subsequent total hip arthroplasty. Historically, using steroids to treat hip osteoarthritis did not seem to work very well. The hip joint is one of the most difficult joints in the body to inject accurately, and entry of the therapeutic agent into the synovial space cannot be ensured without fluoroscopic guidance. The orthopedic surgeon's progress report dated March 6, 2014 documented physical examination of the right hip. There was a well-healed, non-tender incision without signs of infection. The patient's hardware is not palpable. There is some tenderness to palpation of the greater trochanter. She has pain with resisted straight leg raising and axial

compression without irritability. She has a negative Trendelenburg's sign. Range of motion of bilateral hips was flexion 100/110 degrees, extension 0/0 degrees, abduction 50/60 degrees, adduction 15/20 degrees, external rotation 45/60 degrees and internal rotation 10/20 degrees. Right thigh physical examination was documented. There was no localized tenderness, no stretched pain, and no palpable defects. The compartments were soft. There was no localized tenderness over the hamstring muscles or tenderness on the palpable defect. Pelvis physical examination was documented. There was no tenderness to palpation and no pain with compression / distraction of the pelvis. There is a negative FABERE sign. There is no tenderness with a negative Tinel's over the anterior inferior iliac spine and the course of the lateral femoral cutaneous nerve. The patient walks with a slightly antalgic gait with a negative Trendelenburg's sign. Diagnosis was status post ORIF open reduction internal fixation of the right hip fracture in 2007. Intra-articular hip injection was not discussed as a treatment option. The pain management progress report dated April 7, 2014 documented the performance of right hip surgery with the placement of three pins in February 2007. No physical examination of the hip was documented. The pain management physician requested right hip intra-articular injection if cleared by the patient's orthopedic surgeon. No imaging studies of the hip were documented. The orthopedic surgeon's progress report dated March 6, 2014 did not discuss intra-articular hip injection as a treatment option. Because the 4/7/14 pain management progress report did not document a hip physical examination, the 4/7/14 request for a intra-articular glucocorticoid injection of the hip is not supported. The medical necessity of intra-articular injection of the hip is not supported by the medical records. Therefore, the request for right hip intra-articular injection is not medically necessary.