

<b>Case Number:</b>	CM15-0003417		
<b>Date Assigned:</b>	01/14/2015	<b>Date of Injury:</b>	04/21/2008
<b>Decision Date:</b>	03/18/2015	<b>UR Denial Date:</b>	12/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2015

### 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: Preventive Medicine, Occupational 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 is a 56 year old female, who sustained an industrial injury on April 21, 2008. She has reported injuring her back while lifting a 12 pound box. The diagnoses have included lumbar or lumbosacral disc degeneration, unspecified myalgia and myositis and lumbar radiculitis. Treatment to date has included medication and epidural steroid injections. Currently, the injured worker complains of chronic pain in her lumbar spine. She reported that she is taking her medications as prescribed but they are less effective. She feels that a recent epidural steroid injection has completely worn off. She is not able to walk for more than a few minutes and not able to sit for a long period of time. On December 26, 2014, Utilization Review non-certified a right L5 transforaminal epidural steroid injection, right piriformis muscle injection, right greater trochanter bursa injection and physical therapy for right piriformis, noting the California Chronic Pain Treatment Guidelines and Official Disability Guidelines. On January 7, 2015, the injured worker submitted an application for Independent Medical Review for review of a right L5 transforaminal epidural steroid injection, right piriformis muscle injection, right greater trochanter bursa injection and physical therapy for right piriformis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right L5 transforaminal epidural steroid 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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

**Decision rationale:** According to the MTUS, several diagnostic criteria must be present to recommend an epidural steroid injection. The most important criteria are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. The patient had a reported 50% reduction in her low back pain as a result of the previous lumbar epidural steroid injection. I am reversing the previous utilization review decision. Right L5 transforaminal epidural steroid injection is medically necessary.

**Right greater trochanter bursa 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

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

**Decision rationale:** According to the Official Disability Guidelines, trochanteric bursal injections are recommended. For trochanteric pain, corticosteroid injection is safe and highly effective, with a single corticosteroid injection often providing satisfactory pain relief. Trochanteric bursitis is the second leading cause of hip pain in adults, and a steroid-anesthetic single injection can provide rapid and prolonged relief. Particularly in older adults, corticosteroid injection should be considered as first-line treatment of trochanteric bursitis because it is safe, simple, and effective. I am reversing the previous utilization review decision. Right greater trochanter bursa injection is medically necessary.

**Physical therapy for right piriformis:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for

restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Continued physical therapy is predicated upon demonstration of a functional improvement. There is no documentation of objective functional improvement. In the case of this patient, documentation should include stretching routines performed at home of the piriformis muscle, which is required for authorization of a piriformis muscle injection. Physical therapy for right piriformis is not medically necessary.

**Right piriformis muscle 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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Piriformis injections.

**Decision rationale:** Recommended for piriformis syndrome after a one-month physical therapy trial. No consensus exists on overall treatment of piriformis syndrome due to lack of objective clinical trials. Conservative treatment (e.g., stretching, manual techniques, injections, activity modifications, modalities like heat or ultrasound, natural healing) is successful in most cases. For conservative measures to be effective, the patient must be educated with an aggressive home-based stretching program to maintain piriformis muscle flexibility. He or she must comply with the program even beyond the point of discontinuation of formal medical treatment. Injection therapy can be incorporated if the situation is refractory to the aforementioned treatment program. The medical record fails to document the above criteria which are necessary for recommending a piriformis injection. Right piriformis muscle injection is not medically necessary.