

Case Number:	CM15-0008239		
Date Assigned:	01/26/2015	Date of Injury:	03/20/2014
Decision Date:	03/20/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/14/2015

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, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 49-year-old female, who sustained a work related injury on March 20, 2014, after moving and lifting crates. Diagnoses were trochanteric bursitis and low back pain with bilateral radiculitis. Treatment included physical therapy, anti-inflammatory medications, and pain medications. Magnetic Resonance Imaging (MRI) revealed minimal central canal lumbar narrowing. Currently, the injured worker complains increased low back pain radiating into her hip after sitting. On December 31, 2014, a request for a service of 1 trochanteric injection for right hip pain as an outpatient between December 30, 2014 and February 13, 2015 was non-certified by the Utilization Review, noting the ACOEM Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 TROCHANTERIC INJECTION FOR RIGHT HIP PAIN AS AN OUTPATIENT:

Overtured

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Hip & Pelvis, Trochanteric bursitis injections

Decision rationale: The patient presents with low back pain with radiation into her right hip and down both legs, which is worse in the evenings. The current request is for 1 trochanteric injection for right hip pain as an outpatient. The treating physician requests on 12/10/14 (C19) authorization for the patient to receive right greater trochanteric bursae injection. There are no records provided to indicate that the patient has previously received a trochanteric injection for the right hip. MTUS is silent on trochanteric bursitis 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. In this case, the treating physician has documented a diagnosis of right trochanteric bursitis for which corticosteroid injections are recommended per ODG. The current request is medically necessary and the recommendation is for authorization.