

Case Number:	CM15-0106658		
Date Assigned:	06/11/2015	Date of Injury:	06/11/1980
Decision Date:	07/13/2015	UR Denial Date:	05/27/2015
Priority:	Standard	Application Received:	06/03/2015

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: Physical Medicine & Rehabilitation, Pain Management

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 68 year old female, who sustained an industrial injury on June 11, 1980. Treatment to date has included assistive devices, physical therapy and medications. Currently, the injured worker complains of low back pain with radiation of pain to her bilateral legs. She reports no changes in her lumbar spine since her previous evaluation. She describes the pain as aching in nature and rates the pain a 9 on a 10 point scale without medications and a 7 on a 10 point scale with medications. The pain is aggravated with everything and is improved with medications. She reports that her sleep is disturbed with pain. On physical examination, the injured worker ambulated with a can. Her lumbar spine range of motion is limited and she has pain with motion testing. She has positive straight leg raise bilaterally and has tenderness to palpation over the lumbar facet joints and bilateral sacroiliac joints. Her right hip flexion is 5/5 and her left hip flexion is 4/5. She has 5/5 hip extension and adduction bilaterally. The diagnoses associated with the request include thoracic or lumbosacral neuritis or radiculitis, disorder of sacroiliac joint, hip joint pain and lumbosacral spondylosis without myelopathy. The treatment plan includes continuation of Amitriptyline, Norco and Lyrica; decrease OxyContin and right hip intra-articular injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Intra Articular Hip 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, 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 Official Disability Guidelines (ODG), Hip Chapter, Intra-articular steroid hip injection (IASHI).

Decision rationale: Regarding the request for intra-articular hip injection, California MTUS and ACOEM are silent on this issue. ODG states that intra-articular hip injections are not recommended for mild osteoarthritis and understudy for moderate to severe osteoarthritis. If injections are performed, the use of fluoroscopy is required. Within the documentation available for review, there is no indication that the patient has moderate to severe hip osteoarthritis. Additionally, there is no indication of fluoroscopy will be used for the injection. In the absence of clarity regarding those issues, the currently requested intra-articular hip injection is not medically necessary.