

Case Number:	CM15-0147681		
Date Assigned:	08/10/2015	Date of Injury:	06/03/2000
Decision Date:	09/04/2015	UR Denial Date:	06/30/2015
Priority:	Standard	Application Received:	07/29/2015

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

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 male, who sustained an industrial injury on June 03, 2000. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having disc bulge with spondylosis to the lumbar spine along with left sided sacral one radiculopathy, medial meniscus tear to the left knee, and lateral ligament tear to the left ankle. Treatment and diagnostic studies to date has included magnetic resonance imaging of the left knee, medication regimen, and a home exercise program. In a progress note dated May 29, 2015 the treating physician reports complaints of increased pain and spasm to the low back; pain, swelling, and popping to he left knee; and intermittent pain and swelling to the left ankle. Examination reveals a decreased sensation to the posterior and lateral regions of the left foot, decreased range of motion to the left ankle with pain, positive anterior drawer testing to he left ankle, tenderness to the lateral ankle and dorsal surface of the foot, mild effusion to the left ankle, positive valgus and varus stress instability testing, decreased range of motion to he left knee, muscle atrophy to the quadriceps, moderate effusion to the left knee, tenderness to the medial and lateral joint line, pain with McMurray's testing, positive Apley's testing, decreased range of motion to the lumbar spine with pain, spasm to the lower lumbar region that was increased on the left side, tenderness to the lumbar paraspinal muscles, and a positive left Lasegue's testing. The treating physician requested an injection of Dexamethasone 20mg per ml and an injection of Depo-Medrol 40mg per ml, but the documentation provided did not indicate the specific reason for the requested injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective injection Dexamethasone 20mg/ml for DOS 5/29/15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Corticosteroids.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter- Hip, Trochanteric Bursitis/ Intra-articular Injections, pages 268-269.

Decision rationale: Review of medical reports do not identify the indication, joint location, or medical necessity for these steroid injections. Utilization review reports provider's assistant advising the injections were performed in the gluteus/hip muscles. Submitted reports do not identify any symptoms or clinical findings of the gluteal/ hip region. ODG does recommend hip injections as a treatment option with short-term relief for diagnosis of trochanteric bursitis, and not recommended for hip osteoarthritis and is considered under study for moderately advance hip OA. Submitted reports have not adequately demonstrated clear specific symptoms, clinical pathology, and failure of conservative treatment such as NSAIDs and therapy to support for the multiple injections without demonstrated functional improvement not meeting guidelines criteria. There are no specific identified pain relief, functional improvements in terms of increased ADLs, decreased medication dosage, or decreased medical utilization for independent care towards a functional restoration approach. The Retrospective injection Dexamethasone 20mg/ml for DOS 5/29/15 is not medically necessary and appropriate.

Retrospective injection Depo-Medrol 40mg/ml for DOS 5/29/15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Corticosteroids.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter- Hip, Trochanteric Bursitis/ Intra-articular Injections, pages 268-269.

Decision rationale: Review of medical reports do not identify the indication, joint location, or medical necessity for these steroid injections. Utilization review reports provider's assistant advising the injections were performed in the gluteus/hip muscles. Submitted reports do not identify any symptoms or clinical findings of the gluteal/ hip region. ODG does recommend hip injections as a treatment option with short-term relief for diagnosis of trochanteric bursitis, and not recommended for hip osteoarthritis and is considered under study for moderately advance hip OA. Submitted reports have not adequately demonstrated clear specific symptoms, clinical pathology, and failure of conservative treatment such as NSAIDs and therapy to support for the multiple injections without demonstrated functional improvement not meeting guidelines criteria.

There are no specific identified pain relief, functional improvements in terms of increased ADLs, decreased medication dosage, or decreased medical utilization for independent care towards a functional restoration approach. The Retrospective injection Depo-Medrol 40mg/ml for DOS 5/29/15 is not medically necessary and appropriate.