

Case Number:	CM15-0181600		
Date Assigned:	09/22/2015	Date of Injury:	07/18/2013
Decision Date:	11/03/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/15/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, 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:

This 54 year old male sustained an industrial injury on 7-18-13. Documentation indicated that the injured worker was receiving treatment for lumbago, lumbar facet syndrome, lumbar disc displacement and left hip sprain and strain. Previous treatment included physical therapy, left hip arthroscopy (5-2014), cortisone injections, epidural steroid injections and medications. In a progress note dated 7-9-15, the injured worker complained of continuing moderate to severe left groin and lateral hip pain, rated 6 out of 10 of 10 on the visual analog scale, with "minimal" locking. The injured worker stated that he felt he was not improving. Physical exam was remarkable for tenderness to palpation to the anterior lateral hip, range of motion: flexion 15 degrees with guarding and 5 out of 5 left hip flexor and knee flexor and extensor strength. The injured worker sat listing on his right buttock with his left hip "Strader" in the chair. The injured worker walked with a gross limp. The physician noted that the spine surgeon felt the injured worker's symptoms might be due to loose body in the left hip. In a visit note dated 8-19-15, the injured worker had undergone lumbar epidural steroid injection on 8-17-15, with 30% relief in pain and 50% improvement in numbness for 4 days before symptoms returned. The injured worker still had pain from the left buttock to hip and inguinal area, rated 6 to 7 out of 10. The injured worker reported falling on 7-18-15 due to left leg pain and drag with subsequent right hip and leg pain and tremor. Physical exam was remarkable for left hip with tenderness to palpation and range of motion: flexion 8 degrees and abduction, internal rotation and external rotation 10 degrees. The treatment plan included requesting authorization for a left hip injection. On 8-20-15, Utilization Review noncertified a request for a left hip injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left 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, Intraarticular 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 & Pelvis, Intra-articular steroid hip injection.

Decision rationale: Per the ODG guidelines with regard to Intra-articular steroid hip injection: Not recommended in early hip osteoarthritis (OA). Under study for moderately advanced or severe hip OA, but if used, should be in conjunction with fluoroscopic guidance. Recommended as an option for short-term pain relief in hip trochanteric bursitis. (Brinks, 2011) Intraarticular glucocorticoid injection with or without elimination of weight bearing does not reduce the need for total hip arthroplasty in patients with rapidly destructive hip osteoarthritis. (Villoutreix, 2005) A survey of expert opinions showed that substantial numbers of surgeons felt that IASHI was not therapeutically helpful, may accelerate arthritis progression or may cause increased infectious complications after subsequent total hip arthroplasty. (Kasper, 2005) Historically, using steroids to treat hip OA did not seem to work very well, at least not as well as in the knee. However, 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. Fluoroscopically guided steroid injection may be effective. (Lambert, 2007) Corticosteroid injections are effective for greater trochanteric pain syndrome (GTPS) managed in primary care, according to a recent RCT. GTPS, also known as trochanteric bursitis, is a common cause of hip pain. In this first randomized controlled trial assessing the effectiveness of corticosteroid injections vs. usual care in GTPS, a clinically relevant effect was shown at a 3-month follow-up visit for recovery and for pain at rest and with activity, but at a 12-month follow-up visit, the differences in outcome were no longer present. Per the medical records submitted for review, the injured worker had pain from the left buttock to hip and inguinal area rated 6-7/10. He reported falling on 7/18/15 due to left leg pain and drag with subsequent right hip and leg pain and tremor. It was noted that repeat MRI may be warranted, however, it is unclear if this was performed, as results were not available for review. The medical records do not contain diagnostic evidence of osteoarthritis or trochanteric bursitis. Operative report dated 5/15/14 indicates that the injured worker underwent left hip arthroscopy with acetabuloplasty, debridement of labrum and synovium, removal of loose body, microfracture acetabulum, and chondroplasty femoral head. Hip injection is not indicated; the request is not medically necessary.