

Case Number:	CM15-0088336		
Date Assigned:	05/12/2015	Date of Injury:	12/18/2004
Decision Date:	06/12/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	05/07/2015

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: 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 (IW) is a 51 year old female who sustained an industrial injury on 12/18/2004. She reported low back pain. The injured worker was diagnosed as having lumbar disc displacement without myelopathy, pain in joint pelvis thigh, and pain in joint shoulder. She has degenerative disc disease in the lumbar spine resulting in mild central canal stenosis at L4-5 and moderate bilateral neural foraminal stenosis at L4-5 and a right S1 radiculopathy by electromyogram. Treatment to date has included lumbar epidural steroid injections and facet injections (without benefit). Currently, the injured worker complains of pain in the right hip. On physical examination, the lateral hip is aggravated with external rotation and internal rotation. External rotation is 60 degrees, and internal rotation is 50 degrees. Right hip MRI confirms femoacetabular hip impingement. Approval for a right hip cortisone injection is requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Hip Cortisone Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) www.odg-twc.com Section: Hip & Pelvis (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Chapter- Hip, Trochanteric Bursitis Injections, pages 268-269.

Decision rationale: ODG does recommend hip injections as a treatment option with short-term relief for diagnosis of trochanteric bursitis, and not recommended for hip osteoarthritis as in this case and is considered under study for moderately advance hip OA. Besides exhibiting pain on range of motion, clinical pathology, and failure of conservative treatment such as NSAIDs and therapy are not demonstrated to meet guidelines criteria. Additionally, the patient has underwent multiple interventional pain procedure of LESI and facet blocks, no specific functional improvements were documented in terms of increased ADLs, decreased medication dosage, or decreased medical utilization for independent care towards a functional restoration approach. The Right Hip Cortisone Injection is not medically necessary and appropriate.