

<b>Case Number:</b>	CM14-0085101		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	10/17/2005
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	05/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/06/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 63 year old female who reported an injury on 10/17/2005. The mechanism of injury was not indicated. The injured worker's diagnoses included status post right hip arthroplasty, localized osteoarthritis of pelvic region and thigh, sprain and strain of pelvic and thigh region. Past treatment included medications, total right hip replacement with fluoroscopy surgery date unknown. Diagnostic testing was not indicated within the medical records. The injured worker complained of pain to the groin with activity, weakness to the hip and numbness/tingling in the leg which continued even after total right hip replacement surgery. Physical exam revealed tenderness to palpation to the greater trochanter, and positive tenderness to the anterior hip. Range of motion was decreased secondary to pain. Medications included Oxycontin 60mg tab extended release 12 hour 1 tab every 8 hours. The treatment plan was for ultrasound Cortisone injection right hip and epidural spine hip injection. The rationale and the request for authorization form were not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultrasound Cortisone Injection Right Hip:** 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), Hip and Pelvis; Intra-articular Steroid Hip Injection.

**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:** The request for ultrasound cortisone injection right hip is not medically necessary. The patient does have persistent hip and groin pain, and she is status post right total hip replacement. The Official Disabilities Guidelines state Intra-articular steroid hip injection is not recommended in early hip osteoarthritis (OA). It is under study for moderately advanced or severe hip OA, but if used, should be in conjunction with fluoroscopic guidance. Intra-articular steroid hip injection is recommended as an option for short-term pain relief in hip trochanteric bursitis. The injured worker has persistent pain to the hip and groin and is status post total hip replacement; however the guidelines state the cortisone injection should be in conjunction with fluoroscopic guidance. There is a lack of documentation indicating the injured worker has significant functional deficits. There is no indication that the injured worker has significant osteoarthritis to the right hip as the injured worker underwent hip replacement. As such the request is not medically necessary.

**Epidural Spine Hip Injection, Right: 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), Hip and Pelvis; Sacroiliac Joint Blocks.

**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, Sacroiliac joint blocks.

**Decision rationale:** The request for epidural spine right hip injection is not medically necessary. The injured worker has undergone total right hip replacement, however documentation failed to provide the date. The Official Disability Guidelines state the history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings including Cranial Shear Test, Extension Test, Flamingo Test, Fortin Finger Test, Gaenslen's Test, Gillet's Test (One Legged-Stork Test), Patrick's Test (FABER), Pelvic Compression Test, Pelvic Distraction Test, Pelvic Rock Test, Resisted Abduction Test (REAB), Sacroiliac Shear Test, Standing Flexion Test, Seated Flexion Test, and Thigh Thrust Test (POSH).). The guidelines recommend patients undergo 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management prior to receiving a sacroiliac joint injection. The injured work has had total right hip replacement. The injured worker did have documentation of pain to groin and hip. There is a lack of documentation indicating the injured worker has at least 3 provocative tests indicative of sacroiliac joint dysfunction upon physical examination. The documentation failed to prove any previous failed aggressive conservative therapy after surgical intervention. Additionally, the submitted request does not clearly indicate the type of injection being requested. As such the request is not medically necessary.

