

Case Number:	CM14-0171690		
Date Assigned:	10/23/2014	Date of Injury:	01/03/2001
Decision Date:	01/27/2015	UR Denial Date:	09/22/2014
Priority:	Standard	Application Received:	10/17/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in New Jersey. 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 48 year old male who reported an injury on 01/03/2001 when he was mopping and slipped and injured his low back, hip and right shoulder. Diagnosis includes spondylosis, lumbar, right meralgia paresthetica, and status post right hip replacement in 2002. Treating physician's examination note dated 09/06/2014 states the injured worked was complaining of pain in his low back that radiated to the right lower extremity with occasional sharp, shooting pain. He also complained of occasional numbness in feet and legs. Examination notes revealed his low back had limited range of motion due to pain. Bilateral knees and ankles were noted with some sensory loss and diminished reflexes. Right shoulder had a positive Hawkins and Empty can sign. Treatment plan included nerve conduction studies and electromyography (EMG) of lower extremities, follow up MRI of the lumbar spine, pharmacological treatment, selective nerve root block (SNRB), medial branch nerve block and radiofrequency ablative (MBB/RFA), right shoulder and hip injection, physical therapy, acupuncture, and massage. The request is for a left hip injection, ultrasound guided and a right shoulder injection, ultrasound guided that a Utilization Review (UR) denied on 09/22/2014. The request for the office visit was approved to monitor the outcome of treatment for chronic neuro musculoskeletal pain. Regarding the right shoulder injection, ultrasound guided, the UR denied the request due to no documented information regarding the clinical status of the right shoulder examination and no reports pertinent to the right shoulder especially radiographic imaging studies to support the medical necessity. Regarding the left hip injection, ultrasound guided, the UR denied the request due to no documented information regarding clinical status of the left hip examination and no reports pertinent to the left hip especially radiographic imaging studies to support the medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Hip Injection, Ultrasound Guided.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pelvis Chapter - 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) Intra-articular steroid hip injection (IASHI. <http://www.odg-twc.com/index.html>).

Decision rationale: According to ODG guidelines, intra-articular steroid hip injection is 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) Interarticularis 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. (Brinks, 2011). Reviewing the patient file, there is no clinical or radiological evidence of severe osteoarthritis. Therefore, the request for Left Hip Injection, Ultrasound Guided is not medically necessary.

Right Shoulder Injection, Ultrasound Guided.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chapter Shoulder, Steroid injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

Decision rationale: According to MTUS guidelines, shoulder complaints chapter, shoulder injection. Two or three sub- Prolonged or frequent use acromial injections of cortisone injections

local anesthetic and into the sub-acromial cortisone preparation space or the shoulder over an extended joint (D) period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears (C, D). Reviewing the patient file, there is no clinical or radiological evidence supporting that the patient is suffering from a rotator cuff inflammation, impingement syndrome, or small tears. There is no documentation that the treatment is a part of a rehabilitation program. Therefore, the request of Right Shoulder Injection, Ultrasound Guided is not medically necessary.