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| Case Number: | CM15-0018456 | | |
| Date Assigned: | 02/09/2015 | Date of Injury: | 08/14/1998 |
| Decision Date: | 03/25/2015 | UR Denial Date: | 01/26/2015 |
| Priority: | Standard | Application Received: | 01/30/2015 |

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, 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:

The injured worker is a 63 year old male, who sustained an industrial injury on 8/14/1998. He has reported hip, knee and elbow pain. The diagnoses have included degenerative joint disease of hip, osteoarthritis of hip, traumatic arthritis of the left elbow, and osteoarthritis of left knee. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), analgesic, activity modification, ambulatory support. Currently, the IW complains of left elbow and left hip pain. On 1/15/15 physical examination documented hip tenderness, decreased hip Range of Motion (ROM), positive pelvic compression test, pelvic distraction test, Gaenslen's and Gillet's tests, and positive FABER test. Hip x-ray revealed moderate joint space narrowing with gunstock deformity. The plan of care included medications and a future hip joint injection. A January 2015 Utilization Review non-certified a left hip injection arthrogram without anesthesia, noting the documentation failed to support a diagnosis of a labral tear. The ACOEM and ODG Guidelines were cited. On 1/30/2015, the injured worker submitted an application for IMR for review of left hip injection arthrogram without anesthesia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left hip injection Arthrogram without anesthesia: Overturned

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 & Pelvis

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Hip Chapter, Intra-articular hip steroid injection Topic

Decision rationale: With regard to this request, the CA MTUS does not directly address hip injections. Therefore, the ODG Hip Chapter are referenced, which specify the following regarding 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. (Brinks, 2011)"In the case of this injured worker, there is documentation of long standing arthritis, which is at least moderate in severity. The patient is noted on recent exams from January 2015 to have restricted ROM of the hip and positive Faber's maneuver. The pain consultant states the patient has never had a hip injection. Given this, a therapeutic trial of hip joint injection is medically appropriate. It is noted that the UR determination appears to have addressed the incorrect issue. The arthrogram of the hip is not intended for diagnostic imaging, but rather to ascertain placement of injectate into the correct joint space with fluoroscopic guidance. This is documented in a consultation on 1/15/15.