

<b>Case Number:</b>	CM15-0177132		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	12/09/2014
<b>Decision Date:</b>	10/21/2015	<b>UR Denial Date:</b>	08/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2015

### 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 is a 61 year old female, who sustained an industrial injury on December 9, 2014, incurring right knee, right hip and right ankle injuries. She had previous right ankle injuries from 2009, resulting in chronic pain and had surgery with complications in 2010 of the right ankle. She was diagnosed with a sprain of the right knee, bursitis of the trochanteric bursa and a re-injury of the right ankle. Treatment included bilateral knee arthroscopies, bilateral knee replacements, neuropathic medications, topical analgesic gel, antidepressants, transcutaneous electrical stimulation unit, anti-inflammatory drugs, physical therapy, and work modifications. Currently, the injured worker complained of increased pain of the right hip which had not responded well to therapy and medications. She noted that the consistent pain interfered with her activities of daily living including self-care, grooming, and simple activities. The treatment plan that was requested for authorization on September 9, 2015, included transcutaneous electrical stimulation unit and supplied for the right knee and a right trochanteric bursa injection with ultrasound guidance. On August 24, 2015, request for a transcutaneous electrical stimulation unit and supplies was denied and a trochanteric bursa injection was also denied by utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit and supplies for the right knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of TENS Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. From the submitted reports, the patient has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive physical therapy, activity modifications, and surgery yet the patient has remained symptomatic and functionally impaired. There is no documentation on how or what TENS unit is requested, whether this is for rental or purchase, nor is there any documented short-term or long-term goals of treatment with the TENS unit. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the treatment already rendered. The TENS unit and supplies for the right knee is not medically necessary and appropriate.

**Right trochanteric bursa injection with ultrasound guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Ultrasound guidance.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip, Trochanteric Bursitis/ Intra-articular 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 and is considered under study for moderately advance hip OA. Beside exhibiting hip pain complaints, submitted reports have not adequately demonstrated clear specific symptoms, clinical pathology, and failure of conservative treatment such as NSAIDs and therapy to support for the injection without demonstrated functional improvement not meeting guidelines criteria. There are no specific identified pain relief, functional improvements in terms of increased ADLs, decreased medication dosage, or decreased medical utilization for independent care towards a functional restoration approach exhausted. The Right trochanteric bursa injection with ultrasound guidance is not medically necessary and appropriate.