

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/7/2013

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/15/2013
Date of Injury:	8/29/2010
IMR Application Received:	7/30/2013
MAXIMUS Case Number:	CM13-0004622

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for a 9CC 14 percent Marcaine right trochanteric bursa injection - 1cc Depo Medrol **is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/30/2013 disputing the Utilization Review Denial dated 7/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/9/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for a 9CC 14 percent Marcaine right trochanteric bursa injection - 1cc Depo Medrol **is medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

The IMR applications shows a injury date of 8/29/10. The 8/19/13 report from Dr [REDACTED] states the patient has a right hip problems as well as lower back and right shoulder problems. The right trochanteric bursa was injected back in March 2013 and was denied by UR. The physician has recommended right hip iliotibial band windowing, and possible trochanteric osteoplasty. The current diagnosis remains chronic trochanteric bursitis. She takes Votaren ER, Vicodin, Prilosec, Flexeril and Colace.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

- 1) **Regarding the request for a retrospective request for a 9CC 14 percent Marcaine right trochanteric bursa injection - 1cc Depo Medrol :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guideline (ODG), Hip and Pelvis Chapter, Intra-articular steroid hip injection (IASHI), which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on Official Disability Guidelines (ODG), Hip Chapter, Trochanteric bursa injections.

Rationale for the Decision:

Official Disability Guidelines (ODG) recommends for trochanteric pain, corticosteroid injection is safe and highly effective, with a single corticosteroid injection often providing satisfactory pain relief. Trochanteric bursitis is the second leading cause of hip pain in adults, and a steroid-anesthetic single injection can provide rapid and prolonged relief. Steroid injection should be offered as a first-line treatment of trochanteric bursitis, and trochanteric corticosteroid injections are a simple, safe procedure that can be diagnostic as well as therapeutic. Review of the submitted medical records indicates that the employee has a diagnosis of chronic trochanteric bursitis; therefore the request meets the ODG Guidelines. **The request for a retrospective 9cc 14 percent Marcaine right trochanteric bursa injection- 1cc Depo Medrol is medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/db

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.