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**Notice of Independent Review Decision Notice  
of Independent Medical Review Decision  
Reviewer's Report**

**DATE OF REVIEW:** July 19, 2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Left hip intra-articular joint injections.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

M.D., Board Certified in Physical Medicine and Rehabilitation.

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

The requested left hip intra-articular joint injections are not medically necessary.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Notice of Utilization Review Findings dated 6/16/10 and 6/28/10.
2. Request for a Review by an Independent Review Organization dated 6/29/10.
3. IRO request form submitted by dated 6/29/10.
4. TDI Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 6/30/10.
5. TDI Notice to IRO of Case Assignment dated 6/30/10.
6. Occupational Medicine Clinic Follow-up note from, MD, dated 6/3/10.
7. Request for Reconsideration dated 6/15/10.
8. Letter from Dr. dated 6/17/10.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

A review of the record indicates the patient was injured on the job in xxxx. On 6/3/10, the patient's provider noted the patient had complaints of pain in the left hip and he was unable to sleep without his medication. His symptoms started when he swung his legs out while climbing a ladder, he heard a pop, and felt pain. He is status post left hip arthroscopic surgery for superior acetabular tear in xxxx with some improvement in his symptoms. The patient's physician has requested coverage for left hip intra-articular joint injections. The patient received a steroid injection into his hip in the past and the records indicate it did not provide any relief. The Carrier has denied coverage for the requested service indicating that it is not medically necessary for treatment of the patient's osteoarthritis.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

According to the Official Disability Guidelines and Treatment Guidelines (ODG), intra-articular steroid hip injections are not recommended for osteoarthritis. Specifically, the ODG Guidelines state the following with regard to intra-articular steroid hip injections, “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. Intra-articular 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 [intra-articular steroid hip injection] 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) See also Sacroiliac joint blocks; Sacroiliac joint radiofrequency neurotomy; & Intra-articular growth hormone (IAGH) injection.” Per the ODG Guidelines, intra-articular steroid injection would be unlikely to be of any benefit in this clinical setting. The ODG’s recommendation against giving intra-articular steroid injection is particularly appropriate in this case given that the submitted records document that this patient has already received an intra-articular steroid injection and the injection did not help his pain. Thus, based on the submitted medical records and accepted ODG Guidelines, I have determined that the requested service is not medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)