

SENT VIA EMAIL OR FAX ON
Nov/03/2010

Independent Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Nov/02/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Hip Intra-Articular Cortisone Injection w/Fluro Arthrogram

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

Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

X-ray Right hip: 04/07/10

Dr.: 05/12/10

Physical Therapy evaluation: 07/19/10

Dr.: 07/06/10, 08/31/10

Peer Review: 09/03/10, 09/13/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained a work related injury to her right hip on xx/xx/xx from a slip and fall. She suffered a contusion to her right hip. An x-ray of her right hip on 04/07/10 was normal. The claimant saw Dr. on 05/12/10 and he felt she had reached maximal medical improvement and gave her a 0% impairment rating. When she saw Dr. on 08/31/10, she complained of right hip pain with radiation to the lateral thigh, Dr. observed that the claimant had treated with anti-inflammatories and physical therapy without benefit. On examination the claimant had full range of motion of her hip with pain, 5/5 motor strength, a positive labral compression and her sensation was intact. Dr. recommended an intra-articular steroid injection for her right hip. The recommendation for the intra-articular hip injection was non-certified in two peer reviews as there was no documentation on the claimant's hip x-rays of moderate advanced or severe osteoarthritis of her hip.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The URA reviewers are correct. This is consistent with evidence-based medicine as they are currently under study. There is no documentation of arthritis. It is unclear if they have exhausted a conservative workup, evaluation to include MRI or MR arthrogram. Given the above issues, and based solely on the records provided, the IRO reviewer cannot recommend the proposed procedure as medically indicated and necessary at this time.

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

ACOEM-AMERICA 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)