

SENT VIA EMAIL OR FAX ON
Sep/09/2010

P-IRO Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 405-0878
Fax: (214) 276-1787
Email: resolutions.manager@p-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/09/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left hip Injection

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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
Denial Letters 7/16/10 and 7/30/10
Pain Consultants 1/14/10 thru 7/21/10
Physical Medicine 8/11/09 thru 7/22/10
Dr. 5/25/10
MRI 2/10/10
L Spine 9/2/09
IRO Summary No Date

PATIENT CLINICAL HISTORY SUMMARY

This is a woman with a prior history of cervical and lumbar problems. She injured (exacerbated per a note) her back on xx/xx/xx lifting 50-pound Kitty Litter. She had back pain going to the left and right buttocks and the left groin. The left was worse. The pain continued down the posterior left thigh to the leg. She received chiropractic treatments and saw Dr. He felt her to have strains and radiculitis. Her MRI showed disc degeneration, but no evidence of a disc herniation. She failed to improve with an SI injection and an L4/5 left ESI and L5 transforaminal ESI. Dr. requested the right to perform an injection of the left hip.

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

Dr., Dr., Dr. and Dr. all described back pain. None described any intraarticular pain. Dr. felt there was "low suspicion" of an intrarticular problem, but wanted to proceed with the injection. There is no report of any internal hip pain. There is no x-ray or other radiological study of the

hip. Briefly, there was nothing on clinical examination or radiological study to warrant a suspicion of an intrarticular hip problem. It is not recommended for early hip arthritis, but there is nothing to suggest advanced hip arthritis. Therefore, the request is not medically necessary.

Hip Injections

See [Hyaluronic acid injections](#); [Intra-articular steroid hip injection](#); [Sacroiliac joint blocks](#); [Sacroiliac joint injections \(SJI\)](#); [Sacroiliac joint radiofrequency neurotomy](#); [Trochanteric bursitis injections](#); [Piriformis injections](#); & [Viscosupplementation](#)

Intra-articular steroid hip injection (IASHI)

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. 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](#)) See also [Sacroiliac joint blocks](#); [Sacroiliac joint radiofrequency neurotomy](#); & [Intra-articular growth hormone \(IAGH\) injection](#)

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 KNOWLEDGBASE

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)