



Notice of Independent Review

Decision-WC

DATE OF REVIEW: 9-21-10

CLAIMS EVAL

*Utilization Review and
Peer Review Services*

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN

DISPUTE

Left hip intraarticular injection with fluoroscopy

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

American Boards of Physical Medicine and Rehabilitation and Pain Management

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 3-8-08 MRI of the lumbar spine.
- 3-17-08 MRI of the hip.
- MD., office visits on 4-1-08 and 5-27-08.
- MD., office visits on 9-18-08, 10-16-08, and 7-15-10.
- 10-30-08, the claimant underwent left L4-L5 and L5-S1 epidural steroid injection, as well as trigger point injections at lumbar paraspinal left iliocostalis and iliolumbar muscle groups.
- 8-2-10 MD., performed a Utilization Review.
- 9-7-10 MD., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

3-8-08 MRI of the lumbar spine was normal.

3-17-08 MRI of the hip shows bone marrow edema along the medial aspect of the left femoral neck and inter trochanteric region, findings compatible with a small stress fracture.

4-1-08 MD., evaluated the claimant. The claimant sustained an injury on xx/xx/xx with pain about her left hip. She had plain films and bone scan of her left hip. She never had a lumbar spine workup. X-rays of the pelvis showed hips without degenerative joint disease and sacroiliac joint without sclerosis. Bone scan showed an intertrochanteric left femoral neck stress fracture. X-rays flexion extensions of the lumbar spine showed instability at the L5-S1 with extension angle measures 26 degrees with a 7 mm retrolisthesis in extension with facet subluxation and foraminal stenosis. On exam, the claimant has minimal sciatic notch tenderness on the left. Positive heel SLAP. Equal and symmetrical DTR, absent posterior tibial tendon jerk. No gross motor deficit. The evaluator recommended crutches with toe touch weightbearing.

Follow up with Dr. on 5-27-08 notes the claimant is ambulating in total to weight bearing with her bilateral crutches on her right lower extremity and remains clinically asymptomatic. The claimant is taking Tamoxifen at the direction of her physician for some type of breast related problems. She had a repeat MRI scan of the hip and pelvis. The evaluator felt the claimant will need an internal fixation.

The claimant was evaluated by, MD., on 9-18-08 who notes the claimant has had symptoms since her accidental fall when she worked for xxxx. At his initial consultation, he did not have the benefit of her MRIs, which had already been done and he was reviewing them today. The patient has had MRI of the left hip, which shows bone marrow edema along the medial aspect of the left femoral neck with intertrochanteric region compatible with a stress fracture. This has lead to a continued problem with left hip pain. MRI is dated March 17, 2008. Physical exam shows left hip pain, decreased range of motion, tenderness and radicular pain in the left groin. Physical therapy has helped a little bit. Assessment: Left hip stress fracture, bone marrow edema and continued pain. Plan: He will request a left hip intra-articular injection under fluoroscopic control. The purpose of the injection is to reduce pain, decrease disability and improve function. She continues to take Tamoxifen 200 mg a day for breast cancer. Pain management medications include over-the-counter ibuprofen. He will give her prescription strength ibuprofen today.

Follow up with Dr. on 10-16-08 notes the claimant is continuing to have left hip pain and left lower extremity radiculitis listed at 8/10. He had reviewed her MRI scan and CT scan, which revealed a stress fracture of her left hip, but does not seem to be the generator of this radicular pain in the left lower extremity which goes past the knee pain. Pain score is listed at 9/10. On exam, neurologically she is intact. Straight leg sign is positive on the left side at 50 degrees. Extension and flexion of the back are slightly painful. There are paresthesias in the left buttock. There is a decreased and diminished reflex at knee jerk on the left side. Positive Spring test at L4-5. Assessment: Low back pain, left radicular pain, left hip pain. Official Disability Guidelines are met here for a diagnostic left L4-5 and L5-S1 two-level transforaminal epidural steroid injection, intraoperative epidurogram. Good relief, hopefully, should be obtained after the injections.

On 10-30-08, the claimant underwent left L4-L5 and L5-S1 epidural steroid injection, as well as trigger point injections at lumbar paraspinal left ilicostalis and iliolumbar muscle groups.

Follow up visit with MD., on 7-15-10 notes the claimant is a very pleasant female who returns to the office today for followup. The patient was last seen in 2008. She continues to have left hip pain secondary to a stress fracture in the left hip unrelated to work comp injury. She is scheduled for a right-sided mastectomy tomorrow with reconstruction. She has a history of breast cancer. Pain score today is 3/10. Left hip exam reveals pain with flexion and extension. She is tender to palpation over the left trochanter. Assessment: Left hip pain, history of a small stress fracture femoral neck. Plan: the claimant continues to hurt with range of motion of her left hip. She certainly could benefit from a left intra-articular hip injection. He requested work comp insurance company to approve the patient a left intro-articular hip injection for this patient. She meets ODG Guidelines. The evaluator would like to proceed with an intra-articular steroid injection to the left hip in order to decrease the patient's pain and inflammation and allow her to proceed with active rehabilitation without distress. She was continued with her medications.

On 8-2-10, MD., performed a Utilization Review. It was his opinion that the guidelines do not support intra articular steroid injection for non union, partial non union or pathologic fractures of this hip and this is under study for moderate/advanced osteoarthritis of the hip. This claimant has had long standing left hip pain secondary to stress fracture and there is no documentation of a non union at this time. She also has a history of breast cancer and no subsequent studies are provided in the records to rule out metastasis. Steroid injection is not indicated as therapeutic treatment under the guidelines.

On 9-7-10, MD., performed a Utilization Review. The evaluator reported he had a phone conversation with Dr. PA,. There is documentation of continued left hip pain. However, the medical information including imaging does not demonstrate moderately advanced or severe hip osteoarthritis. Therefore, this request was non certified.

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

MEDICAL RECORDS REFLECT THE CLAIMANT SUSTAINED A LEFT HIP STRESS FRACTURE. SHE WAS TREATED CONSERVATIVELY, BUT CONTINUES WITH PAIN TO THE LEFT HIP. ON EXAM, THE CLAIMANT HAD PAIN WITH FLEXION AND EXTENSION. BASED ON THE RECORDS PROVIDED AND THE CLAIMANT'S SYMPTOM COMPLEX, THE REQUEST FOR A LEFT HIP INTRAARTICULAR INJECTION WITH FLUOROSCOPY IS REASONABLE AND NECESSARY DUE TO HER ONGOING SYMPTOMATOLOGY AND FAILURE WITH OTHER CONSERVATIVE TREATMENTS.

ODG-TWC, last update 8-10-10 Occupational Disorders of the Hip – intra articular injection :

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).

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)