



14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

DATE OF REVIEW: 8/15/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

LEFT HIP STEROID INJECTION

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

M.D. Board Certified in Orthopedic Surgery/ Fellowship trained in Spine 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)



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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Document Type	Date(s) - Month/Day/Year
Texas Department of Insurance Notice of Case Assignment	7/26/2011
Health Care Workers' Comp Services Utilization Review Determinations	7/06/2011-7/12/2011
Orthopedic Group L.L.P. Requests for Pre-Authorization	6/03/2011-7/08/2011
M.D. Office Visit Notes	6/01/2011-7/07/2011

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who has had a total hip replacement (unknown date) on the left prior to this fall from standing height on xx/xx/xx .The patient complains of left hip pain. Clinical note dated 6/01/2011 reported the patient’s MRI of his right shoulder revealed subscapularis tear. In this note the patient stated his shoulder is actually better, but his left hip is worse. He complained of severe pain and discomfort with left hip. The physical examination evidenced a full range of motion in the shoulder. The motor, sensory and neuro are intact. He had no abduction or flexion of the left hip because of severe pain around the anterior groin region and lateral greater trochanter. Previous X-ray report (not dated and no radiologist’s analysis) of the left hip showed no acute changes in the implant position. Recommendation of injection followed by physical therapy for left hip. Current medications not provided in the latest medical record submitted for review.

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

An intra-articular hip injection based on the diagnostic workup provided is not necessary.

Rationale: The diagnosis of post-operative hip pain can be elusive. The differential diagnosis includes both intrinsic and extrinsic causes. Potential pain generators include infection, aseptic loosening, wear debris synovitis, osteolysis, occult instability, iliopsoas tendinitis, stress and insufficiency fracture. It is not clear from this case what is the diagnosis that warrants this intervention. There is no objective documentation of failure of the patient to respond to conservative measures such as pharmacotherapy and physical therapy prior to more invasive treatment as requested. A thorough workup is most likely indicated prior to such an intervention.

References:

1. Official Disability Guidelines.



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2. Evaluation of Patients with Pain Following Total Hip Replacement. *J Bone Joint Surg Am.* 2005; 87:2566-2575

3. INTRA-ARTICULAR LOCAL ANAESTHESIA FOR PAIN AFTER HIP ARTHROPLASTY. *JBJS-Br* 1997; 79-B:796-800

4. Orthopedist's goal in treating unexplained post-THA hip pain is to clarify and resolve. *Orthopedics Today* February 2010.

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