

SENT VIA EMAIL OR FAX ON
May/10/2011

Pure Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/09/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right hip IA Steroid Injection under Fluoro Outpatient

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

Board Certified PMR 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

1. Carrier submission 04/26/11 Law Offices of
2. Notification of determination 03/02/11 regarding non-certification of request for right hip IA steroid injection under fluoro outpatient
3. Notification of determination 03/22/11 regarding non-certification appeal of request for right hip IA steroid injection under fluoro outpatient
4. Office note, M.D. 11/16/10
5. Initial examination and follow-up notes, M.D. 11/19/10-12/27/10
6. Progress notes 12/10/10-12/15/10
7. CT abdomen / pelvis 12/02/10
8. X-rays lumbar spine 2 views 12/10/10
9. MRI lumbar spine 12/21/10
10. Office notes, M.D. 01/10/11 and 02/18/11
11. EMG/NCV consultation, M.D. 01/18/11
12. MRI right hip 01/23/11
13. Operative report caudal lumbar epidural steroid injection 02/04/11 with pre and postoperative records
14. Office notes, M.D. 02/22/11
15. Orthopedic surgeon second opinion, M.D. 03/29/11
16. Work comp verification for diagnostic / surgical procedures 11/19/10
17. Work comp verification for diagnostic / surgical procedures 02/24/11

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male whose date of injury is xx/xx/xx. Records indicate he fell out of a cab overtype truck approximately 4 ½ to 5 feet landing on his right hip and buttock. MRI lumbar spine performed 12/21/10 revealed degenerative disc disease at L2-5 with neural foraminal encroachment. Electrodiagnostic testing on 01/28/11 revealed right sided L3-4 radiculopathy.

Lumbar epidural steroid injection was performed on 02/04/11 with only about 10-20% improvement. MRI of the right hip was performed on 01/23/11 and revealed no evidence of right hip fracture. There was a posterolateral labral tear noted. The injured employee was seen by Dr. on 01/10/11 with chief complaint of low back pain. The injured employee was noted to have been on Aleve and Medrol DosePak. Physical examination noted the injured employee was only mildly tender across the lumbar spine. There is no chest pain, no shortness of breath, no nausea or vomiting, no abdominal pain, and no bowel or bladder dysfunction. The injured employee walked with a slight limp. Any motion of the right hip causes pain. He has pain with iliopsoas function. He has burning along the anterior thigh. He has 1.5 to 2 cm of atrophy of the right thigh compared to left. He has good quadriceps function. He has good hamstring function. The injured employee was seen in follow-up on 02/18/11 with complaints of low back, right leg pain and groin pain. Physical examination reported range of motion of hip does not hurt. His FAI test was minimally positive. Circulation and sensation were intact. There was full power of quad, iliopsoas and hamstrings. There was tenderness along the inguinal ligament and along adductor muscles. No hernia was felt. Dr. noted MRI showed posterolateral labral tear, but doubts if this is the cause of any symptomatology.

A request for right hip intraarticular steroid injection under fluoro was determined as non-certified on 03/02/11. The reviewer noted that the clinical findings submitted failed to meet practice guidelines for the service requested. Physical examination from 02/22/11 noted negative straight leg raise bilaterally, positive reverse straight leg raise on the right and negative contralateral straight leg raise bilaterally. Right hip was tender in the groin. There was decreased range of motion with internal rotation with adductor strength 5/5 and flexor 4/5 bilaterally. Decreased sensation was noted on the right anterior thigh but did not specify if light touch or temperature sensation was utilized. No documentation was provided noting reflexes of the right lower extremity. It was noted that EMG/NCV performed 01/18/11 of the right lower extremity provided definitive evidence of no peripheral neuropathy. It was further noted that it was unclear how an injection into the hip joint would address femoral neuropathy. It was further noted that no documentation was provided on any attempts at conservative treatment done previously, the injured employee's response to aggressive physical therapy program or medication management plans.

A reconsideration/appeal request for right hip IA steroid injection under fluoro was determined as non-certified on 03/22/11. It was noted that guidelines do not recommend intraarticular hip injections for early hip osteoarthritis. There was a lack of documentation as to what if any conservative treatments the injured employee tried for his hip symptoms. There is mention of physical therapy, but no documentation as to the injured employee's response to physical therapy.

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

Based on the clinical information submitted for review, medical necessity is not established for right hip IA steroid injection under fluoro outpatient. The injured employee is noted to have sustained an injury when he fell from a truck approximately five feet on xx/xx/xx. The injured employee complained of right hip pain as well as low back pain. The injured employee underwent caudal lumbar epidural steroid injection on 02/04/11 without significant improvement. MRI of the right hip on 01/23/11 reported posterolateral labral tear with no evidence of right hip fracture. The notes indicate that the pathology identified was not felt to be a pain generator. X-rays of the right hip revealed no fracture, dislocation or subluxation. There is no comprehensive history of conservative treatment completed for the right hip. Per ODG guidelines, intraarticular steroid injection of the hip is not recommended in early hip osteoarthritis, and is under study for moderately advanced or severe hip OA. Noting there is no objective evidence of significant osteoarthritis of the right hip, medical necessity is not established.

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)