

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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IRO CASE #: 39853

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Intraarticular Steroid Injection Right Hip. CPT Code: 20610.

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

DIPLOMATE, AMERICAN BOARD OF ANESTHESIOLOGY
DIPLOMATE, AMERICAN ACADEMY OF 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

Medical records from the Carrier/URA include:

- Official Disability Guidelines, 2008
- N.P., 11/03/11
- 11/21/11, 01/03/12
- Pain Management, P.A., 12/27/11
- M.D., 02/15/12

Medical records from the Provider include:

- Pain Management, P.A., 03/02/12
- N.P., 01/07/11, 02/04/11, 03/07/11, 04/04/11, 05/06/11, 06/06/11, 07/05/11, 08/04/11, 09/02/11, 10/05/11, 11/03/11

PATIENT CLINICAL HISTORY:

The Description of Services in Dispute: Intra-articular steroid injection to right hip. CPT Code: 20610.
The review outcome is upheld of previous non-authorization for requested services.

This is a male who sustained a work-related injury on xx/xx/xx, involving the lumbar spine secondary to a lifting-type mechanism. The patient has been involved with the Workers Compensation System since xxxx and undergoing extensive amounts of treatment consisting of physical therapy, medication management, and individual pain management injections. Lumbar spinal surgery was recommended years later, but the patient refused surgery.

Currently, the patient is under the care of pain management physician, M.D., who is providing medication management consisting of narcotics and muscle relaxants. From the last submitted note from this treating physician dated November 3, 2011, the patient's diagnosis includes lumbar/low back pain and lumbosacral radiculopathy.

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

All diagnostic studies included in this review deal solely and mainly with the lumbar spine. There are no submitted medical documentations for the medical necessity of providing this patient an intra-articular steroid injection in the right hip. It is not clear to the reviewer how the right hip complaints are related to the patient's work-related injury occurring in xxxx involving the lumbar spine.

The medical necessity, at the request and according to the ODG Guidelines, could not be established. Therefore, the previous non-authorization for an intra-articular steroid injection to the right hip has been upheld. References: The Official Disability Guidelines, Treatment Index, 9th Edition, Webb 2011, Hip-Cortisone Injection.

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)