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Notice of Independent Review Decision

DATE OF REVIEW: 10/19/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a Left Greater Trochanter Bursal Injection.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a Left Greater Trochanter Bursal Injection.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

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PATIENT CLINICAL HISTORY [SUMMARY]:

According to available medical records, this is a xx. The patient was injured on xx/xx/xx while pulling a piece of equipment. She reportedly developed a burning sensation in her lower back radiating down both posterior thighs. On xx/xx/xx, she saw P.A. who prescribed a Medrol Dosepak, Lortab, and Flexeril for lower back pain. The injured worker began physical therapy on May 4, 2012 and reportedly had 12 physical therapy sessions which did not resolve her symptoms.

X-rays of the lumbar spine were performed on May 15, 2012. These showed mild levoscoliosis of the lumbar spine with facet joint degenerative changes at L5-S1. MRI studies of the lumbar spine performed on May 18 showed mild disk bulge with facet hypertrophy at L2-3 with mild reduction in the right and left neural foramen, a posterior disk bulge and bilateral facet joint hypertrophy at L4-5 causing mild central canal stenosis and narrowing of the neural foramina, and L5-S1 bilateral facet joint hypertrophy without spinal canal stenosis or foraminal stenosis.

On July 12, 2012, the injured worker was evaluated by M.D. Dr. xxxx noted the reported injury, symptoms, and the fact that the injured worker did not improve with physical therapy. He recommended electrodiagnostic studies and these were performed on August 9, 2012. Dr. performed the studies and reported that the electrodiagnostic studies were within normal limits. Dr. described a positive Faber test bilaterally as well as tenderness over the left greater trochanter. He concluded that the injured worker had both facetogenic pain in the lower back, left greater than right, and bilateral sacroiliac joint dysfunction. He further stated that tenderness over the left greater trochanter could represent concomitant left greater trochanteric bursitis. Dr. recommended bilateral sacroiliac joint injection and a possible left greater trochanteric bursal injection.

On August 13, 2012, D.O., diagnosed a lumbar sprain and recommended a TENS unit as well as physical therapy and light duty.

On August 24, 2012, the injured worker had a Designated Doctor Evaluation by M.D. Dr. reported that the injured worker was at maximum medical improvement on that date with a 5% whole person impairment.

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

Recommended approval of requested services. This worker had a reported injury on xx/xx/xx in a work-related incident. She reportedly developed lower back pain radiating to both posterior thighs. Diagnoses entertained by treating physicians and therapists included low back sprain, sacroiliac joint dysfunction, and possible left greater trochanteric bursitis.

The injured worker had 12 physical therapy visits without significant relief of her symptoms. She had multiple medications including oral steroids, analgesics, and muscle relaxers. Steroid injections were recommended for her sacroiliac joints as well as her left greater trochanteric bursitis.

It is unclear if this injured worker developed trochanteric bursitis at the time of her initial injury or if the bursitis may have developed as a result of her antalgic gait or other concomitant

factors. The first mention of trochanteric bursitis was approximately four months after her initial injury, but the examining physician clearly felt that there was an element of trochanteric bursitis with tenderness over the greater trochanter, an antalgic gait, and a positive Faber sign bilaterally. No neurologic deficits were documented in the left lower extremity. The injured worker's examination was consistent with trochanteric bursitis and ODG Treatment Guidelines recommend steroid injections as a first-line treatment for trochanteric bursitis because it is safe, simple, and effective. The ODG Treatment Guidelines note that this injection can be used both diagnostically as well as therapeutically. This injection would help clarify if trochanteric bursitis is a significant pain generating source as suggested by the examining physician, Dr. . While a trochanteric bursal injection may not resolve this injured worker's pain issues, it would likely assist in diagnosing whether or not trochanteric bursitis is contributing to her pain complaints and would likely reduce or resolve the portion of the pain caused by trochanteric bursitis.

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)**