



Medwork Independent Review

5840 Arndt Rd., Ste #2
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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

Date: July 11, 2013

DATE OF REVIEW: 7/9/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The intra-articular injection of the left hip under fluoroscopic guidance.

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

Texas State Licensed MD Board Certified Orthopedic Surgeon.

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

1. Dept of Insurance Assignment to Medwork 6/21/2013,
2. Notice of assignment to URA 6/20/2013,
3. Confirmation of Receipt of a Request for a Review by an IRO 6/21/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 6/20/2013

Notes from patient not dated, letter to physician from insurance plan 6/14/2013, letter regarding patient 6/13/2013, letter to physician from insurance plan 6/7/2013, letter regarding patient 6/7/2013, reconsideration request 6/5/2013, review analysis 5/24/2013, history and physical exam 5/22/2013, health insurance claim form 5/15/2013, review analysis 5/9/2013, medical notes 5/8/2013, referral and letter of medical necessity for PT/OT 5/6/2013, health insurance claim form 4/29/2013, 4/25/2013, medical notes 4/24/2013, shoulder exercise sheet, medical notes 4/22/2013, review analysis 4/22/2013, lower extremity function scale 4/5/2013, health insurance claim form 4/4/2013, referral and letter of medical necessity for PT/OT 4/1/2013, operative report 3/22/2013, review analysis 1/8/2013, medical notes, health insurance claim form 12/31/2012, billing notes 11/26/2012, anesthesia record 10/31/2012, hospital workers'



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compensation verification form 10/29/2012, report of medical evaluation 9/11/2012, health insurance claim form 9/11/2012, MMI report 9/11/2012, impairment rating 9/11/2012, ODG Guidelines.

PATIENT CLINICAL HISTORY:

The patient is a female who was injured on xx/xx/xx. The claimant, despite non-operative and then operative arthroscopic surgery to the left hip joint, has gone on to have recurrent pain in the left hip. The patient postoperatively, after the arthroscopic debridement of degenerative labral tear with acetabular chondroplasty along with femoroplasty of the anterior femoral head and neck, has had postoperative therapy, medications, restricted activity, and a greater trochanteric bursal injection of cortisone. The cortisone injection did not significantly decrease the hip pain. On the most recent visit, the patient has been documented to have pain on motion of the left hip in addition to tenderness over the greater trochanter. There was consideration for an intra-articular injection of the left hip performed under fluoroscopy. Denial letters indicated that this was being considered as a repeat injection despite the fact that the prior injection was documented to have been to the outer aspect of the hip joint itself, i.e. to the greater trochanter just underneath the skin and subcutaneous and fascial tissue. Appeal letters discussed the persistent pain in the patient's left hip including the appeal letter from the patient.

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

The patient has subjective and objective complaints at the level of the left hip joint itself based upon painful motion of the hip. The patient is status post intra-articular extensive arthroscopic surgery. The patient clearly has at least postoperative inflammation and plausible ongoing exacerbation of underlying at least moderately severe osteoarthritis of the hip joint itself. In this clinical situation of both the injection and localization of the hip joint via fluoroscopy as requested are reasonable and medically necessary as the applicable ODG criteria supports a case by case consideration of same. The ODG criteria at least indicates that such a consideration is under study and therefore in this consideration specifically and uniquely being a postoperative injection under fluoroscopy of the actual hip joint itself (as opposed to the previously injected trochanteric bursa external to the joint) is reasonable and medically necessary in order to decrease and/or in any event treat the postoperative inflammation and at least moderately severe osteoarthritis. This is based on the overall intent of the clinical applicable ODG criteria.

The denial of these services is overturned.



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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)