IRO NOTICE OF DECISION – WC

Notice of Independent Review Decision

September 8, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right hip steroid injection

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

American Board of Anesthesiology

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 medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

5-14-14 performed a Peer Review. It was his opinion that the most recent clinical visit occurred on April 17, 2014 where she was being seen in regards to her prior

shoulder injury occurring on xx/xx/xx. On this occasion, she continues to be followed for the xx/xx/xx incident in conjunction with subjective complaints of discomfort involving her right shoulder. The record indicated that she was scheduled to see on July 10, 2014. She is still reporting shoulder pain with VAS scores of 4/10. Additional notes indicated that she has been experiencing low back pain and was previously taken off work by a general surgeon, who according to does not treat back or disc injuries. Review of the physical therapy evaluation report from 04/2212014 indicates low back pain and VAS scores of 4/10 with increased discomfort associated with bending, twisting and standing. Her Low Back Oswestry indicated a 60% perceived disability. She reports pain and generalized tenderness over her lumbar muscles. He was aware that was recently seen by orthopedic surgeon; however, the current medical records do not include medical report. On 04/16/2014, was seen where she was complaining of lower back pain and pain in her legs. indicates reports the pain is 4/5 sharp pain that radiates from her low back down to her legs. Review of the clinical data does not indicate any objective findings. There are reports of generalized pain and tenderness. On 04/16/2014, was also reporting abdominal pain but there were no objective findings noted. Review of clinical evaluation of 04/17/2014 makes no reference as regard to any clinical findings referable to her lower back. A report of 04/22/2014 demonstrates no objective clinical findings. In reality, the medical records have not demonstrated any reflex loss. Sensory, motor and range of motion are all subjective in nature. Initially, the clinical records indicated the presence of some ecchymosis over her lower abdomen and right lower extremity but all that resolved spontaneously. The current diagnosis according to the most recent medical records is low back pain, lumbar disc disease with radiculopathy which is inaccurate, a work-related injury nonspecific and herniated discs. If one refers to the MRI scan report, it indicates a grade I spondylolisthesis of L5 on SI; however, that diagnosis is not confirmed by any other radiologist on two prior clinical examinations. There were also inconsistent reports of postural impairment, gait alterations, restricted joint motion, core muscle weakness all of which are subjective issues. The most appropriate clinical diagnosis associated with the date of incident is non-specific low back pain, abdominal contusions (verifiable), buttock and sacral contusions (invisible) and a possible invisible non-specific unverifiable soft tissue injury commonly labeled as a sprain/strain syndrome (subjective). The only diagnosis which is current which would be causally associated with the incident is low back pain non-specific. The patient has degenerative disc disease as reported on the MRI scan which is not associated with the occupational injury. There is no medical data to support a clinical diagnosis of lumbar radiculopathy. The CT scan obtained on 03/26/2014 was ordered who practices as a pain management physician. The study was read where he reports a 2-mm posterior central disc protrusion which mildly impinges the thecal sac. He indicates specifically that the paralumbar soft tissues and paravertebral muscles are normal. He also indicates there was a grade I spondylolisthesis of L5 on S1. A grade I spondylolisthesis would be a translation from 0-25% of the vertebral body length in the AP direction. Previous x-rays obtained on 01/21/2014 and again on 02/26/2014 make no reference of a grade I spondylolisthesis at L5-S1. He was familiar with the practice patterns and customs. He believed his reports the one he was able to review the films personally to determine whether or not his

report is consistent with the images that he saw. When in doubt, he would always recommend sending films out for an over read by a board-certified radiologist. He had no medical records indicating that has been treated or had any significant injuries to her lower extremities, low back, abdomen or pelvis. Review of the initial documentation indicates the presence of abdominal contusions which can be visualized with associated ecchymosis. The low back, sacrum and buttock injury certainly could have occurred as a result of her fall to the floor. In essence, Ms. sustained a contusion to her sacrum and buttocks which also resulted in some low back pain. Given the clinical findings associated with the abdomen and ilioinguinal area, it is more probable than not that he also sustained a direct contusion of her abdomen with some other object that has never been represented or discussed. The MRI scan read is unremarkable except for the questionable grade 1 spondylolisthesis at L5-S1. The small disc protrusions of 2 mm are of no clinical significance. Prior x-rays demonstrated no evidence of a spondylolisthesis. He had no problems accepting that Ms. indeed sustained direct contusions as a result of the occupational event. It is also possible she sustained invisible, nonspecific, unverifiable soft tissue injuries which have been labeled as sprain/strain syndromes. He had no data indicating that any of Ms. medical conditions associated with a prior shoulder injury were indeed aggravated, made worse, or escalated. It appears she still continues to treat and will most likely continue to treat until his services are no longer paid for. The contusions which have been reported in the medical records in all probability are associated with the occupational event. No specific pain generator has ever been demonstrated. There has been no evidence that Ms. has experienced muscle spasms for three months. Further data does not indicate any arthritic condition or any inflammatory condition which still exists which would indeed be causally connected to the xx/xx/xx incident. The current pharmaceutical prescriptions which are being issued are predicated simply on their practice patterns and customs. In all probability, the claimant has reached her preinjury status. One would have anticipated this to occur certainly within six to eight weeks post incident.

5-27-14, the claimant complains of right leg pain. She states the pain starts in her gluteal area when she is sitting or walking for even a modest amount of time. The pain then radiates down her leg towards her knee and does not go below her knee. Impression: Probable right piriformis syndrome due to piriformis muscle spasm, possible right sacroiliitis. Plan: The claimant will be referred for an injection.

6-4-14, the evaluator noted that the claimant presents for an evaluation. The claimant complains of right hip and buttock pain. Since her injury the claimant has completed a course of conservative medical care including medication, physical therapy, and a home exercise program. The evaluator recommended a steroid injection into the right piriformis musculature.

6-11-14, the evaluator noted that the claimant returned for a follow up. After informed consent, the claimant was given 2 injections into the right piriformis musculature of the right posterior hip using Depo Medrol with Xylocaine.

7-11-14 Left Mammogram with Computer aided detection Bilateral Breast Sonogram.

7-23-14, the evaluator recommended an injection.

7-23-14, the evaluator noted that the claimant returned for a follow up after her first right hip steroid injection. The claimant states after her injection she noted moderate clinical improvement with 50% reduction in pain, improving range of motion and better tolerance for activities of daily living. Her pain remains greatest in the posterior joint line. The evaluator recommended active physical therapy.

7-25-14, performed a Peer Review. It was her opinion that a right hip steroid injection was not necessary. The diagnosis was piriformis syndrome, not hip degeneration. The pain doctordid a piriformis injection and wants to repeat it. He did not suggest a right hip injection. There was no indication of osteoarthritis in the hip either.

8-7-14, performed a Peer Review. It was his opinion that he was unable to approve for medical necessity with application of ODG/Hip Chapter/intra-articular steroid hip injection. The request is going to peer review because the patient does not have a diagnosis of osteoarthritis or trochanteric bursitis. Per ODG-Not recommended in early hip osteoarthritis (OA). Under study for moderately advanced or severe hip OA, but if used, should be in conjunction with fluoroscopic guidance. Recommended as an option for short-term pain relief in hip trochanteric bursitis. She has complained of back & right leg pain since that time. On 6/6/14, she had a right piriformis musculature injection. The current notes states that she still has right leg pain & pain at the edges of the sacrum that radiates toward the right greater trochanter. Another note states that she has pain over the right piriformis musculature. The notes state that she had a right hip steroid injection 6 weeks ago. He did not see that anywhere in the system. He only saw the right piriformis musculature injection.

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

Medical records reflect a claimant with back, right hip and buttock pain. The claimant has been treated conservatively. Most recently she was given a piriformis injection with reported 50% improvement. There is a request for right hip steroid injection. Current treatment guidelines reflect that this form of treatment is not recommended in early hip osteoarthritis (OA). It is under study for moderately advanced or severe hip OA, but if used, should be in conjunction with fluoroscopic guidance. It is recommended as an option for short-term pain relief in hip trochanteric bursitis. Based on the records provided, there is an absence in

documentation noting the claimant has bursitis or moderately to severe hip osteoarthritis. Therefore, the request for a right hip steroid injection is not medically necessary.

Per ODG 2014 intra articular steroid hip injection: Not recommended in early hip osteoarthritis (OA). Under study for moderately advanced or severe hip OA, but if used, should be in conjunction with fluoroscopic guidance. Recommended as an option for short-term pain relief in hip trochanteric bursitis. (Brinks, 2011) Intraarticular glucocorticoid injection with or without elimination of weight-bearing does not reduce the need for total hip arthroplasty in patients with rapidly destructive hip osteoarthritis. (Villoutreix, 2005) A survey of expert opinions showed that substantial numbers of surgeons felt that IASHI was not therapeutically helpful, may accelerate arthritis progression or may cause increased infectious complications after subsequent total hip arthroplasty. (Kasper, 2005) Historically, using steroids to treat hip OA did not seem to work very well, at least not as well as in the knee. However, the hip joint is one of the most difficult joints in the body to inject accurately, and entry of the therapeutic agent into the synovial space cannot be ensured without fluoroscopic guidance. Fluoroscopically guided steroid injection may be effective. (Lambert, 2007) Corticosteroid injections are effective for greater trochanteric pain syndrome (GTPS) managed in primary care, according to a recent RCT. GTPS, also known as trochanteric bursitis, is a common cause of hip pain. In this first randomized controlled trial assessing the effectiveness of corticosteroid injections vs usual care in GTPS, a clinically relevant effect was shown at a 3-month follow-up visit for recovery and for pain at rest and with activity, but at a 12-month follow-up visit, the differences in outcome were no longer present. (Brinks, 2011)

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)**