

ReviewTex. Inc.
1818 Mountjoy Drive
San Antonio, TX 78232
(phone) 210-598-9381 (fax) 210-598-9382
reviewtex@hotmail.com

Notice of Independent Review Decision

Date notice sent to all parties:

September 28, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CPT – 73721 MRI; any joint lower extremity, without contrast
CPT – 27093 NIX PX HIP ARTHG W/O ANES
CPT – 76942 US NDL PLMT IMG S&I

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

Board Certified Orthopedic Surgeon (Joint)

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

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]:

The patient is a female. On xxxxxxx, the patient was seen. She had a complaint of pain to the foot and ankle with swelling to the bottom of the foot which remained unchanged since the last visit. She also noted right shoulder pain consistent with falling on outstretched hands. She reported right shoulder pain had been aggravated by the use of crutches. On 04/02/15, x-rays of the left hip had been obtained showing no significant abnormality of the left hip identified. No acute fracture or dislocation was noted and the left hip joint space was preserved. On

04/18/15, an MRI of the left hip revealed a high grade partial thickness tear of the gluteus medius tendon at the lateral facet attachment of the greater trochanter, measuring 10mm in the AP dimension. No fracture or malalignment was evident and the cartilage and labrum appeared normal. On 05/08/15, the patient was seen in clinic. She reported continued left hip pain located bilaterally which did not radiate into her groin. On exam of the lumbar spine she had normal strength with flexion and extension. Left hip exam revealed no tenderness and there was no laxity noted. Strength was 5/5. She did have a positive impingement sign on the left hip. Right hip exam revealed negative anterior impingement sign. An MR arthrogram with a simultaneous steroid injection for both therapeutic and diagnostic purposes was recommended.

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

On 05/22/15, a utilization review report noted the request was non-certified and the rationale given was that Official Disability Guidelines indicate that attempt at conservative care for the hip would be indicated prior to repeat MRI study and therefore the request for an MR arthrogram of the left hip with an injection was neither medically necessary nor appropriate. On 06/19/15, a utilization review report noted the requested MRI with arthrogram and injection to the left hip, was not authorized, and it was noted there was no indication that the patient had hip osteoarthritis as the provided imaging reported the acetabular cartilage appeared normal. It was reported that guidelines indicate hip injection is not recommended in early hip osteoarthritis and is under study for moderately advanced or severe hip osteoarthritis and therefore the request was non-certified. On 07/29/15, an adverse determination letter was submitted noting the request was not authorized. The Official Disability Guidelines hip chapter was utilized, noting that steroid injection for moderately advanced or severe hip osteoarthritis if used, should be in conjunction with fluoroscopic guidance, and although there was a positive impingement sign there was no indication on the recent MRI of any labral pathology and no physical therapy notes were submitted for review.

Physical therapy notes have been submitted for this review and indicate that an ankle exercise flow sheet was submitted noting stretching had been performed to the lower extremities. Cold packs with electrical stimulation were also given to the left ankle and to the left hip. However, the MRI and x-rays of the left hip failed to demonstrate any significant pathology such as osteoarthritis or a labral tear. Guidelines indicate that intraarticular steroid injections to the hip are not recommended in early hip osteoarthritis and are under study for moderately advanced or severe hip osteoarthritis. Therefore, the issues raised on initial determination have not been resolved. It is the opinion of this reviewer that the request for CPT code 73721, MRI any joint in the lower extremity without contrast, CPT code 27093, NIX PX hip arthrogram without anesthesia and CPT code 76942, US needle placement imaging SNI is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Intra-articular steroid hip injection (IASHI)

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) See also Sacroiliac joint blocks; Sacroiliac joint radiofrequency neurotomy; Trochanteric bursitis injections; & Intra-articular growth hormone (IAGH) injection.

Arthrography

Recommended for suspected labral tears. (American, 2003) Magnetic resonance images of asymptomatic participants with no history of pain, injury, or surgery may reveal abnormalities

in 73% of hips, with labral tears being identified in 69% of the joints. A strong correlation was seen between participant age and early markers of cartilage degeneration such as cartilage defects and subchondral cysts. (Register, 2012) Arthrography gains additional sensitivity when combined with CT in the evaluation of internal derangement, loose bodies, and articular cartilage surface lesions. (Colorado, 2001) Magnetic resonance (MR) arthrography has been investigated in every major peripheral joint of the body, and has been proven to be effective in determining the integrity of intraarticular ligamentous and fibrocartilaginous structures and in the detection or assessment of osteochondral lesions and loose bodies in selected cases. (Sahin, 2006) A combination of MR arthrography and a small field of view is more sensitive in detecting labral abnormalities than is conventional MRI with either a large or a small field of view. (Toomayan, 2006) (Temmerman, 2005) One meta-analysis recommends subtraction arthrography over contrast arthrography for detection of loosening of total hip prostheses, especially for evaluation of the femoral component. (Temmerman2, 2005) While both MRI (0.5-3T) and MRA (0.5-3T) have moderate sensitivity and specificity (sensitivity 66%, 87%; specificity 79%, 64%), diagnostic accuracy of MRA appears to be superior to MRI in detecting acetabular labral tears on ROC curve interpretation. When magnetic resonance magnet strength was restricted to 1.5-T, the pooled sensitivity for MRI was 70% and the pooled specificity was 82%. The pooled sensitivity for MRA was 83% and the pooled specificity was 57%. (Smith, 2011) However, recent reports have shown similar accuracy when MRA is compared with MRI when an optimized hip protocol and 3.0-T magnets are used. (Register, 2012) (Sundberg, 2006)

Indications for imaging -- Magnetic resonance imaging:
Osseous, articular or soft-tissue abnormalities
Osteonecrosis
Occult acute and stress fracture
Acute and chronic soft-tissue injuries
Tumors

Exceptions for MRI
Suspected osteoid osteoma (See CT)
Labral tears (use MR arthrography unless optimized hip protocol and MRI with 3.0-T magnets)