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DATE: 2/24/18
IRO CASE #: XXXX
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right Hip Intra-articular Injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is certified by The American Board of Anesthesiology and has over 10 years of experience.

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]:
Claimant is a XXXX with current complaints of compensable right hip pain radiating to the right side of XXXX groin and low back pain radiating to the right calf after a work related injury on XXXX. XXXX, XXXX on XXXX back and right hip.

XXXX: Office Visit with XXXX. After injury, pt c/o chronic right radicular ,lumbar pain without current imaging and with current physical exam findings of severe muscle guarding and sacroiliac mobility deficits, with positive sacroiliac provocative test, but negative segmental rigidity and radiculopathy. Pt has compensable right hip labral tear and sprain and lumbar strain and right SI joint sprain. The patient has noncompensable disputed right hip effusion, paralabral ganglion cyst, lumbar radiculopathy, early hip DJD, and earl lumbar DJD, and hip chondromalacia. Chronic right hip pain with accepted labral tear and sprain, and with imaging showing labral injury, with denied injection and labral debridement surgery, with current physical exam findings of severe tenderness and guarding and mobility deficits, with a positive Trendelenburg test substantial weakness without neurovascular complaints. Pain is 7/10 and made worse by all standing activities and by prolonged sitting including, climbing and squatting, and made better by rest only. Pt notes weakness, numbness, and burning in XXXX right leg in a sciatic distribution down to the calf without any other neurovascular complaints. Pt ambulates with a mildly antalgic gait on the right side, able to squat walk 10 degrees on the right but down to 60 degrees on the left. Toe heel is normal. Hip tenderness is worse in the posterior femoroacetabular joint with only mild tenderness anteriorly, and more moderate to severe tenderness over the greater trochanter and posterior piriformis area. Lumbar 60 degrees flexion/ 15 degrees extension. Severe tenderness over the left sacroiliac joint. Sacroiliac tests Gaenslen, and FABER are moderately positive on the right side only. Hip is painful with more the 10 degrees internal rotation, external rotation more than 30 degrees, abduction more than 15 degrees. Straight leg raise produces

back pain at 60 degrees right/80 degrees left. Pt is still quite symptomatic in the hip and labral debridement has been requested and denied, so this patient makes a good candidate for Surgical Option Process combined with functional restoration to assess whether its possible to avoid the surgery or that it is necessary to be performed. XXXX takes hydrocodone 10mg t.i.d. and naproxen b.i.d.

XXXX. UR by XXXX. Rationale- The medical records provided for review shows that the claimant has continued pain in the right hip. According to the guidelines, an intra-articular steroid hip injection is only recommended for short term relief of pain for trochanteric bursitis. There was no evidence in the records provided that the claimant was suffering from trochanteric bursitis in the right hip. Also, there is no diagnostic imaging made available for review to support the request. Request is denied. Peer-to peer caller was unable to provide additional information that would enable certification.

XXXX: Injection Consultation with XXXX. Pt has current c/o compensable right hip pain radiating to the right side of XXXX groin and low back pain radiating to the right calf. Pain is continuous and frequently severe, and modified by increase in activity level. XXXX has had appropriate diagnostic testing and therapeutic procedures up to the present. XXXX has completed 25 of XXXX 80 hours of physical therapy, but has continued to have pain in XXXX right hip. MRI on XXXXwas suggestive of a right hip labral tear, along with chondromalacia in the right articular cartilage. XXXX continues to have right-sided hip pain with prolonged walking or sitting. Pain is sore with internal and external rotation. There is tenderness with palpation over the right piriformis muscle. Straight leg raise is negative. ROM is limited secondary to pain, particularly with internal and external rotation. Positive FABER maneuver of the right hip resulting in right anterior hip pain. Right hip labral tear and sprain. Based on pt's physical exam and history, I have recommended right hip intra-articular injection under fluoroscopic guidance.

XXXX: Reconsideration Letter by XXXX. There was a misunderstanding with the "non-surgeon" peer review doctor, this doctor misunderstood the request for a trochanteric bursa injection, which was never the request, and for which the wrong diagnosis was read by the peer doctor under the ODG. The peer doctor got all of this wrong despite the data sent and the peer call. This patient was denied a surgical debridement of the accepted diagnosis of right hip "labral tear" in favor of the recommendation for an injection. Now, that injection request for MRI proven right hip labral tear accepted by the carrier has also been denied for confusion. This confusion should not be allowed to cause another extensive delay of a month for making an appropriate decision by a surgeon who understands that a labral tear is appropriately treatment by an intra-articular fluoroscopic guided injection under ODG and under current appropriate treatment.

XXXX. Office Visit with XXXX. Pt returns today after having an inappropriate denial of XXXX intra-articular injection for XXXX left hip "labral tear". You had asked for surgery and pointed out an injection trial was needed before surgical intervention could be tried. The labral tear is accepted as compensable by the carrier. Yet, the peer doctor either did not read the material or failed understand that the request was for intra-articular fluoroscopy guided injection of the hip to help in the Surgical Option Process decision that you will ultimately face at program XXXX.

XXXX: UR by XXXX. Rationale- Per ODG, the only recommended indication for intra-articular hip injections is moderately advanced or severe osteoarthritis. The records only show "early" degenerative joint disease. Furthermore, monitored anesthesia care is not needed for routine joint injections. A successful peer-to-peer call with XXXX was made. During the conversation, the case was discussed in detail with regard to the provided medical records, guidelines, and request. XXXX agreed to withdraw the request for monitored anesthesia care. However, the indication for the procedure was confirmed to be inconsistent with ODG recommendations.

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

The previous adverse decisions are upheld. Based on the records submitted and peer reviewed guidelines, this request is not certified. Per ODG, the only recommended indication for intra-articular hip injections is moderately advanced or severe osteoarthritis. The records only show "early" degenerative joint disease. Furthermore, monitored anesthesia care is not needed for routine joint injections. Therefore, the request for Right Hip Intra-articular Injection is considered not medically necessary.

PER ODG…..

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