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Notice of Independent Review Decision

DATE OF REVIEW: 12/11/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Total hip replacement versus total hip resurfacing on the right with a three to four day inpatient length of stay

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

Board Certified in Orthopedic Surgery

REVIEW OUTCOME

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

X 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.

Total hip replacement versus total hip resurfacing on the right with a three to four day inpatient length of stay - Upheld

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

The Employer's First Report of Injury or Illness form on xx/xx/xx indicated the

patient was injured on xx/xx/xx in a motor vehicle accident (MVA) and sustained multiple neck injuries. On 07/27/07, Dr. recommended continued acupuncture and medications. An MRI of the lumbar spine interpreted by Dr. on 08/10/07 revealed annular discs from L4-S1. A right groin ultrasound interpreted by Dr. on 10/02/07 revealed a right inguinal hernia. A CT scan of the abdomen and pelvis interpreted by Dr. on 10/18/07 revealed a non-obstructive left renal calculus only. On 10/29/07, Dr. stated there was no evidence of a hernia. On 11/12/07, Dr. recommended an MRI of the hips and an EMG/NCV study of the lower extremities. Physical therapy was performed with Ms. on 11/12/07, 11/15/07, 11/20/07, 11/21/07, and 11/28/07. An EMG/NCV study interpreted by Dr. on 11/13/07 was unremarkable. An MRI of the right hip interpreted by Dr. on 11/16/07 revealed mild osteoarthritic change of both hips. On 11/19/07, Dr. recommended a pain management evaluation and a trial of injection therapy. On 12/06/07, Dr. recommended lumbar epidural steroid injections (ESIs). On 03/04/08, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 5% whole person impairment rating. An MRI of the right hip interpreted by Dr. on 05/01/08 showed an acetabular labral tear with adjacent paralabral cyst within both hips. An ESI was performed on 05/15/08. On 09/25/08, Dr. recommended an arthroscopic debridement or joint replacement. On 10/23/08, Dr. recommended hip resurfacing. On 10/31/08, Dr. wrote a letter of adverse determination for the surgery. On 11/07/08, Dr. also wrote a letter of adverse determination for the surgery.

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

The patient does not have very significant hip arthritis. He is under xx years old with a date of birth of xx/xx/xx. He does not meet the criteria set forth by the ODG for total hip replacement, which states an individual should be over 50 years old. Second, the patient has a labral tear. A total hip arthroplasty or hip resurfacing is a dramatic treatment for this. The MRI on 05/01/08 revealed a labral tear, but a previous MRI in 2007 did not show it. The patient is not suffering from significant functional deficits. A total hip arthroplasty is not the appropriate procedure to be performed at this time. Therefore, utilizing the screening criteria provide by the ODG, the requested total hip replacement versus total hip resurfacing on the right with a three to four day inpatient length of stay is neither reasonable nor necessary.

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 AND KNOWLEDGE BASE**

- [ ] 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
- [x] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- [ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- [ ] MILLIMAN CARE GUIDELINES
- [x] 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)