

# MEDR X

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 01/04/10

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The services under dispute include the medical necessity of a left total hip arthroplasty with a 3 day LOS (27130)

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

**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)

The reviewer disagrees with the previous adverse determination regarding the medical necessity of a left total hip arthroplasty with a 3 day LOS (27130)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties: , MD and the patient. These records consist of the following:: preauth request of 11/10/09, 9/8/09 script by Dr. and 11/24/09 appeal of preauth request.

Dr.: progress notes of 9/16/09 to 11/4/09 and 11/20/09 denial letter by Dr..

Patient: SOAP notes from, MD of 8/5/09 to 11/9/09.

We did not receive the WC Network Treatment Guidelines from Carrier/URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The review is regarding a gentleman who was injured on xx/xx/xx when he fell on his right side. The records from Dr. indicate that his hip was stiff and tender and that he ambulates with an antalgic gait. X-rays revealed chronic osteoarthritis with AVN and femoral head collapse. The diagnosis was ongoing aggravation of OA and AVN. The patient has failed treatment with medications, injectibles (including intra-articular under fluoroscopic guidance), and restricted activities. Dr., xxxxxx reviewer, indicates there is no documentation of physical therapy treatments. He also noted that the claimant's BMI was not documented and that the criteria of the ODG were not met. The 12/8/09 reconsideration review also noted that a weight bearing radiograph was not included for review. The appeal by the attending physician is dated 11/20/09 in which the BMI was noted to be 25 and he was indicated to have failed at physical therapy. He was also noted to have an antalgic Trendelenburg gait with a lurch-sway to the spine.

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

The claimant has failed all reasonably required non-operative treatment for this ongoing aggravation of the condition of advanced avascular necrosis (AVN) with osteoarthritis (OA) of the left hip. The subjective and objective findings correlate with the quite descriptive and sufficient report of the x-rays. The age and BMI are appropriate under the ODG as well. The claimant has a medical indication for the proposed procedure; therefore, it is medically necessary based upon the records presented.

**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 KNOWLEDGBASE
- 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)