

# C-IRO Inc.

An Independent Review Organization  
7301 RANCH RD 620 N, STE 155-199A  
Austin, TX 78726  
Phone: (512) 772-4390  
Fax: (512) 519-7098  
Email: resolutions.manager@ciro-site.com

## NOTICE OF AMENDED INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Feb/16/2010

**DATE OF AMENDED REVIEW:**

Feb/24/2010

**IRO CASE #:**

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

Left total hip replacement surgery

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

MD, Board Certified Orthopedic Surgery

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 12/15/09, 11/19/09  
Orthopedic Center 1/19/10, 11/3/09, 8/6/09, 6/30/09  
Medical Center 1/5/10  
Imaging Center 11/2/09, 6/22/09  
Hospital 7/21/09  
M.D. 6/5/09  
Occupational Health Systems 11/30/09  
ODG Guidelines and Treatment Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male who was injured on xx/xx/xx. He apparently tripped on a can and fell. He had pain in the hip and was diagnosed as having avascular necrosis. An intraarticular injection of cortisone injection was performed, which did not help. Current request is for total hip replacement.

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

Based upon the patient's age and clinical presentation, he does not meet the criteria, according to the medical records presented and the Official Disability Guidelines and Treatment Guidelines for total hip arthroplasty, i.e. loss of range of motion or nighttime pain, over 50 years of age, or in younger cases, when the hip is shattered, and body mass index is less than 35. However, given his age and the absence of collapse noted on the MRI scan, the patient does not satisfy ODG criteria. It is for these reasons that the previous adverse determination cannot be overturned. The reviewer finds that medical necessity does not exist for Left total hip replacement surgery.

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

- ACOEM-AMERICA 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)