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DATE OF REVIEW: 03/15/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

IRO - Revised Hip Joint replacement; CPTR-Asst Dir MS PX

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

This case was reviewed by a Texas licensed MD, specializing in Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

ABMS Orthopaedic Surgery

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
IRO - Revised Hip Joint replacement; CPTR-Asst Dir MS PX	27134, 20985	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	Referral	Exhibits, claim file	5		
2	Claim File	Dr.	2	02/04/2010	02/04/2010
3	Impairment/Disability Rating Report	Evaluation Center	6	09/02/2008	09/02/2008
4	Designated Doctor Report	Dr.	10	02/25/2009	02/25/2009
5	Designated Doctor Report	Dr.	12	06/26/2009	09/25/2009
6	Diagnostic Test	Radiological Assoc	8	03/14/2008	12/11/2009
7	Op Report	Hospital	5	03/24/2009	03/24/2009
8	Claim Notes	Hospital	19	02/29/2008	06/27/2008

9	Impairment/Disability Rating Report		5	10/07/2009	10/07/2009
10	Claim Notes	Non-cert letter	2	01/21/2010	01/21/2010
11	Claim Notes	Non-cert Letter	2	02/11/2010	02/11/2010
12	Op Report	Surgery Center	1	12/04/2008	12/04/2008
13	Office Visit Report	Bone and Joint Clinic	17	01/08/2009	11/03/2009
14	Office Visit Report	Dr.	2	10/30/2009	10/30/2009
15	Office Visit Report	Dr.	4	10/31/2008	11/20/2008
16	Office Visit Report	Orthopaedic	20	05/28/2008	01/26/2009
17	Office Visit Report	Orthopaedic Clinic	2	12/18/2008	12/18/2008
18	Office Visit Report	Dr.	8	05/06/2008	03/09/2009
19	PT Notes	Physical Therapy	40	06/02/2008	10/27/2008
20	PT Notes	Physical Therapy	4	05/12/2009	05/12/2009
21	UR Request	UR Findings	6	01/21/2010	02/11/2010
22	Designated Doctor Report	DDE Summary	10	02/10/2009	02/10/2009
23	First Report of Injury	FROI	1	03/07/2008	03/07/2008

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female employee of the xxxx who fell down a flight of stairs on xx/xx/xx suffering a sprained right ankle. She was evaluated at Hospital Emergency Room and diagnosed with a sprained ankle. She was treated with orthotic support, physical therapy, medications and activity modification. An MRI scan of the right ankle and foot, 3/14/08, revealed multiple ligament grade 1 sprains and resolving hematoma. She suffered a subungual hematoma of the great toe and the toenail was removed. She had injections into the 2nd MTP joint. She was treated with phonophoresis and activity exercises during physical therapy sessions. Eventually her foot and ankle pain resolved. She then developed left hip pain. X-rays of the left hip revealed osteoarthritic changes. MRI scan performed on 7/18/08 confirmed joint effusion, greater trochanteric irritation compatible with gluteus medius tendonopathy. She was treated with physical therapy, medication, activity modification and local corticosteroid injection in the region of the greater trochanter. Incidentally, she underwent bunion surgery and second metatarsal osteomy of the left foot. She was treated with medication, activity modification and physical therapy for the left hip pain. An MRI scan of the lumbar spines 11/21/2008 revealed spondylosis, degenerative disc disease multiple levels including L3-L4 and L4-L5. Epidural steroid injection was performed 12/04/08. She was evaluated by a number of physician/surgeons with recommendations for fluoroscopic guided intra-articular steroid injections and total hip arthroplasty. A total hip arthroplasty was performed 03/24/2009. She required high dose narcotic medication in the post operative period. She has suffered abduction contracture of the hip with pelvic tilt. Persistent greater trochanteric bursitis is present. She has complained of inability to sit for long periods. She has L5 root symptoms. MMI was assigned as of 09/25/09 with a 30% WPI. An impairment rating/medical review report was performed 10/07/09 resulting in an impairment rating of 0% by disregarding the hip pathology and findings. A request to preauthorize revision total hip arthroplasty has been considered and denied; reconsidered and denied.

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

Medical necessity for the performance of a revision total hip arthroplasty has not been established. The source of this patient's pain has not been adequately investigated. It appears that this patient's pain prior to the total hip arthroplasty of 03/24/09 was not relieved at all. A revision of this total hip arthroplasty would likely result in persistent pain. Revision total hip arthroplasty would not be appropriate at this time. There has been no evaluation of the possibility that this hip has an indolent infection. The abduction contracture has not been investigated or adequately treated. According to the ODG, 2010, hip chapter passage cited above, revision total hip arthroplasty is indicated for failed total hip arthroplasty, This total hip arthroplasty has not been proven as a failed procedure. Further investigation and less aggressive treatment appear indicated. Revision total hip arthroplasty does not appear indicated at this time.

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

Revision total hip arthroplasty	Recommended for failed hip replacement or internal fixation. Revision total hip arthroplasty is a reasonably safe and effective procedure for failed hip replacement. (Saleh, 2003)
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- 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
- 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)

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on 03/15/2010.

