



**Notice of Independent Review Decision  
IRO REVIEWER REPORT – WC (Non-Network)**

**DATE OF REVIEW:** 04/19/11

**IRO CASE #:**

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

Outpatient Left Hip MRI w/o Contrast

**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:

- 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.

Outpatient Left Hip MRI w/o Contrast – UPHELD

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Lumbar Spine CT - 12/05/07
- Left Hip and Lumbar Spine X-Rays - 12/05/07
- Emergency Physician Record - 12/05/07
- DWC Form 73, M.D., 12/08/07
- Multi-Trauma Follow Up, M.D., 12/06/07, 12/13/07, 12/27/07, 01/08/08, 01/31/08, 02/05/08, 02/18/08, 02/29/08, 03/10/08, 04/10/08, 05/08/08, 05/22/08, 07/10/08, 09/09/08, 10/06/08, 01/06/09, 02/06/09, 03/05/09, 04/07/09, 05/08/09, 06/05/09, 06/19/09, 07/13/09, 07/30/09, 09/01/09, 10/21/09, 12/03/09, 12/11/09, 12/18/09
- DWC Form 73, Dr., 12/06/07, 12/13/07, 12/27/07, 01/08/08, 01/31/08, 02/05/08, 02/18/08, 02/29/08, 03/10/08, 04/10/08, 05/08/08, 05/22/08, 07/10/08, 09/08/08, 10/06/08, 01/06/09, 02/06/09, 03/05/09, 04/07/09, 05/08/09, 06/05/09, 06/19/09, 07/13/09, 07/30/09, 09/01/09, 10/21/09, 12/03/09, 12/11/09, 12/18/09
- Initial Evaluation/Plan of Care, Physical Therapy, 12/21/07
- Lumbar Spine X-rays, M.D., 01/04/08
- Lumbar Spine MRI, Dr., 01/04/08
- Evaluation, M.D., 01/24/08

- Evaluation, M.D., 01/31/08
- Initial Evaluation, M.P.T., 02/05/08
- Initial Examination, M.D., 03/28/08
- DWC Form 73, Dr., 03/28/08
- Pelvis CT Scan, 04/30/08
- Follow Up Examination, Dr. 05/09/08
- Maximum Medical Improvement (MMI) Evaluation, Dr. 05/22/08
- Functional Capacity Evaluation (FCE), 06/16/08, 12/09/09
- Therapy, P.T., 06/17/08, 06/19/08, 06/23/08, 06/24/08, 06/25/08
- Initial Visit Comprehensive Evaluation, M.D., 08/28/08
- Follow Up Office Visit, Dr., 10/30/08, 01/02/09, 01/15/09, 01/29/09
- Procedure Note, Dr., 12/18/08
- Emergency Physician Record, 12/19/08
- Office Visit Follow Up, 02/26/09, 05/14/09
- Designated Doctor Evaluation (DDE), M.D., 05/12/09, 10/07/09
- Evaluation, M.D., 07/07/09
- Left Hip MRI, M.D., 07/27/09
- Employee's Request to Change Treating Doctor, 10/21/09
- Correspondence, Clinic , 11/18/09
- Initial Medical Report, D.C., 03/15/11
- Lumbar MRI, M.D., 03/23/11
- Denial Letter, 03/23/11, 03/28/11
- Lumbar Hip MRI Request, 03/23/11
- Letter of Medical Necessity, Dr., 03/23/11
- The ODG Guidelines were not provided by the carrier or the URA.

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient was injured on XX/XX/XX after falling down a flight of stair, riding on her left hip down the flight. She felt pain immediately. The patient had been treated with therapy, medications and nerve blocks. An MRI of the lumbar spine and CT of the pelvis were also performed.

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

The patient has had extensive evaluation of this hip with CT scans and with MRI, all indicating mainly degenerative change about the hip with no other significant finding. The current medical records do not document a current plain film x-ray of the hip that would make one suspicious of pathology about the hip other than the degenerative changes that have been noted on multiple examinations to date. With this patient's body habitus being X feet, XX inches tall and weighing XXX pounds, this could exacerbate the pain from the degenerative changes of the hip, but at this time the medical records do not document a physical examination finding that would support re-examination of the hip with a repeat MRI without contrast.

**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)
- AMA GUIDES 5<sup>TH</sup> EDITION