



791 Highway 77 North, Suite 501C-316 Waxahachie, TX 75165
Ph 972-825-7231 Fax 972-775-8114

Notice of Independent Review Decision

DATE OF REVIEW: 1/24/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a total hip replacement and an inpatient surgical room (27130, RC111).

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. This 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 agrees with the previous adverse determination regarding the prospective medical necessity of a total hip replacement and an inpatient surgical room (27130, RC111).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with a history of childhood Perthes disease of left hip. He was injured on xx/xx/xx while. Mechanism of injury is unclear from provided records, but majority appears to be anoxia. Patient rehabilitated extensively with minor complaints of hip discomfort over months following the injury. No hip fractures were noted in initial evaluation or discharge summary. No permanent impairment was attributed to hip by two physicians performing disability evaluation in 2007. X-rays reveal enlarged femoral head with degenerative changes and collapse. Those changes are compatible with Perthes late sequelae. Complaints of hip

pain were noted 8/2010 by Dr., treated and referred to Dr. who has recommended total hip reconstruction.

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

The reviewer notes that the injury is not documented to the hip; previous existing disease is causative of the condition. Lastly, the patient does not meet ODG guidelines as noted below. Therefore, the requested procedure is found to not be medically necessary at this time based upon the records provided.

ODG Indications for Surgery -- Hip arthroplasty:

Criteria for hip joint replacement:

1. Conservative Care: Medications. OR Steroid injection. PLUS
2. Subjective Clinical Findings: Limited range of motion. OR Night-time joint pain. OR No pain relief with conservative care. PLUS
3. Objective Clinical Findings: Over 50 years of age (but younger OK in cases of shattered hip when reconstruction is not an option) AND Body Mass Index of less than 35. PLUS
4. Imaging Clinical Findings: Osteoarthritis on: Standing x-ray. OR Arthroscopy.

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)**