



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision
REVISED REPORT
 Corrected services in dispute

DATE OF REVIEW: 09/11/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopy, hip with femoroplasty, arthro hip with acetabuloplasty, arthro hip with labral repair, incision of hip tendon with 23-hour observation and CPM machine.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis Code	Service Being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim #	Upheld Overturn
719.45	29914		Prosp.						Upheld
843.8	29915		Prosp.						Upheld
	29916		Prosp.						Upheld
	27005		Prosp.						Upheld
	E0935		Prosp.						Upheld
	E0188		Prosp.						Upheld

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient was involved in a motor vehicle accident on xx/xx/xx. He suffered multiple musculoskeletal injuries, the left hip being compensable. The mechanism of injury was not included in the records provided to me. Evidently the patient had significant pain with radiation from the left hip down the leg and has been treated and worked up for evaluation of soft tissue impingement. MR arthrogram was eventually performed of the left hip. This showed no evidence of labral pathology. It showed some chondral thinning and osteochondral lesion in the hip without evidence of loose body. The hip was slightly dysplastic. No secondary reactive changes consistent with FAL were noted. No acetabular labral tear was noted. Multiple arthroscopic procedures including 23-hour observation and hip tendon release were recommended and denied by the insurance company.

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

There are many reasons that this request for surgery did not conform to the ODG Guidelines. One, there is no

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definitive imaging evidence of labral pathology; two, there are no loose bodies; three, the mechanism of injury is clearly not defined in the medical records; four, the requesting surgeon has not provided an adequate rationale for all of the various procedures requested for this patient and as they appear to be excessive. Until these issues are clarified, the request is not medically reasonable or necessary.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)