

# **INDEPENDENT REVIEWERS OF TEXAS, INC.**

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 04/23/2012

**IRO CASE #:**

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

Non certification of inpatient admission on 3/2/12 and a stay for 3-21 days

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

Board Certified Orthopedic Surgeon (joint)

**REVIEW OUTCOME:**

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

X 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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

1. IRO referral documents
2. Patient information sheet
3. Lab results sample taken 03/02/12
4. Surgery scheduling form
5. Surgery preoperative orders 03/02/12
6. Orthopedic preoperative antibiotics
7. Office visit 03/02/12
8. CT scan left leg 03/02/12
9. Operative report incision and drainage, left infected trochanteric bursitis, and bursectomy with debridement and irrigation
10. Postoperative visit 03/21/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male whose date of injury is xx/xx/xx. Records indicate the claimant is status post left total hip arthroplasty in 2008. The patient presented on

03/02/12 with complaints of left hip pain. The claimant was noted to have been working and doing fine but noticed two days ago increased swelling around distal incisional scar. On examination there was tenderness to palpation of lateral swollen mass distal incision. There is 10 cm radius mass lateral and distal incision; tender to touch; no redness. The site was aspirated by sterile technique with 10 mm of frank pus seen. CT scan was obtained on 03/02/12 and reported left hip replacement in good position. There was multilocular abscess collection seen in left lateral thigh, subcutaneous tissue and possible secondary area deep to fascial layer. Lab results indicated elevated C-reactive protein and elevated sedimentation rate. The patient was admitted and underwent surgical intervention on 03/03/12 with incision and drainage of left infected bursitis, and bursectomy. The patient was seen in postoperative follow-up on 03/21/12. Sutures were removed on this date and wound was noted to be healing well.

A preauthorization request for medical necessity of inpatient admission on 03/02/12 and stay for 3 to 21 days was reviewed on 03/06/12 and determined as not medically necessary. It was noted that the claimant is a 61 year-old diabetic with left hip pain. He previously underwent left hip arthroplasty. It was said that the hip arthroplasty is infected, but there was no complete blood count or other information supporting the diagnosis of infection. An incision and drainage with possible removal of the prosthesis was to be performed. There was insufficient information upon which to base a cogent determination of medical necessity.

A reconsideration request was reviewed on 03/14/12 and the request was non-certified as medically necessary. It was noted that the claimant is a male who sustained an injury on xx/xx/xx. He subsequently was diagnosed with an infected trochanteric bursitis of the left hip and went to surgery 03/03/12 where IND of the trochanteric bursa was performed as well as bursectomy. Prior history was that of left total hip arthroplasty in 2008. The claimant post-op was hospitalized the day of the surgery. Medical records fail to document and rationale why there was a necessity for hospitalization. Although there is concern for possible infection the fluid was noted to be straw colored and the operative report does not document findings supportive of a need for hospitalization as IV medication can be performed on an outpatient basis.

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

The request for inpatient admission with 3-21 day stay is not supported as medically necessary; however, a partial certification of a three day inpatient stay would be appropriate. The claimant is status post left total hip arthroplasty in 2008. He presented on 03/02/12 with complaints of left hip pain and reported noticing two days prior increased swelling around the distal incisional scar. On examination there was a 10cm raised mass lateral and distal incision, tender to touch. This was aspirated with 10mm of frank pus seen. CT scan revealed multilocular abscess collection in the left lateral thigh subcutaneous tissue and

possible secondary area deep to the fascial layer. Noting the evidence of florid infection, inpatient admission for surgical intervention was appropriate. A total of three day inpatient stay also would have been appropriate. Thereafter the claimant could have been discharged with outpatient IV antibiotics administered.

Reference:

Official Disability Guidelines, Hip and Pelvis Chapter

**ODG hospital length of stay (LOS) guidelines:**

**Total Hip** (*icd 81.51 - Total hip replacement*)

Actual data -- median 3 days; mean 3.6 days ( $\pm 0.0$ );

Best practice target (no complications) -- 3 days

**Partial Hip** (*icd 81.52 - Partial hip replacement*)

Actual data -- median 5 days; mean 6.6 days ( $\pm 0.1$ );

Best practice target (no complications) -- 5 days

**Hip Replacement Revision** (*icd 81.53 - Revision of hip replacement, not otherwise specified*)

Actual data -- median 4 days; mean 5.8 days ( $\pm 0.3$ );

Best practice target (no complications) -- 4 days

**Closed Reduction** (*icd 79.75 - Closed reduction of dislocation of hip*)

Actual data -- median 2 days; mean 2.9 days ( $\pm 0.1$ );

Best practice target (no complications) -- 2 days

**Open Reduction** (*icd 79.85 - Open reduction of dislocation of hip*)

Actual data -- median 4 days; mean 5.0 days ( $\pm 0.4$ );

Best practice target (no complications) -- 4 days

**Hip Arthroscopy** (*icd 80.15 - Other arthroscopy, hip*)

Actual data -- median 6 days; mean 8.6 days ( $\pm 0.3$ );

Best practice target (no complications) -- 6 days

**Arthroscopy Prosthesis Removal** (*icd 80.05 - Arthroscopy of hip for removal of prosthesis*)

Actual data -- median 7 days; mean 9.5 days ( $\pm 0.3$ );

Best practice target (no complications) -- 7 days

**Destruction Hip Lesion** (*icd 80.85 - Other local excision or destruction of lesion of hip*)

Actual data -- median 5 days; mean 7.0 days ( $\pm 0.5$ );

Best practice target (no complications) -- 5 days

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

**X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**