

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/19/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Total Hip Replacement w/ 3 Day LOS 27130

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

M.D., Board Certified Orthopedic Surgeon (Joint)

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 medical necessity exists for each health care service in dispute. The reviewer finds medical necessity does not exist for Left Total Hip Replacement w/ 3 Day LOS 27130.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury on xx/xx/xx when a cable caught her legs. The patient underwent radiographs of the left hip on 12/21/11, which revealed normal alignment and normal joint space in the left hip. There was a known posterior left acetabular wall fracture; however, this was poorly evaluated on the radiographic study. The patient was status post left hip arthroscopy with capsulectomy and synovectomy on 03/21/12. The patient underwent postoperative physical therapy through 06/12. The patient then underwent manipulation under anesthesia with arthrography on 07/02/12. The procedure report indicated marked thinning and narrowing of the femoral side of the left hip with an absence of loose bodies. Clinical evaluation on 08/21/12 stated that the patient continued to report groin pain and there was limited short-term relief from the manipulation under anesthesia procedure from 07/12. Physical examination revealed limited range of motion in the left hip with no internal rotation, 10 degrees of adduction, and 20 degrees of abduction. Stinchfield's test was positive and left hip strength was mildly reduced. Radiographs were stated to show progressive congruent loss of the joint space in the left hip with a new onset of osteophyte formation. No radiographic reports were provided for review.

The request for left total hip replacement with 3-day length of stay was denied by utilization review on 09/10/12 as there was no clinical documentation regarding the patient's BMI and no updated imaging studies including recent radiograph studies indicating specific pathology.

The request was again denied by utilization review on 10/16/12 as there was no radiology report regarding updated imaging studies of the left hip and no documentation to indicate that the patient failed to respond to non-surgical treatment modalities to include activity

modifications and bracing.

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

To date, the patient is status post two surgical procedures to include a manipulation under anesthesia with arthrography on 07/02/12. The procedure report indicated thinning and narrowing of the femoral side of the left hip with no evidence of loose bodies. There was no documentation regarding any interval conservative treatments up to 08/21/12 and no further clinical documentation after 08/21/12 was provided for review documenting additional conservative treatment. The patient's BMI remains unclear from the clinical documentation provided for review and radiographs that were stated to show congruent loss in the joint spaces of the left hip with onset of osteophyte formation were not provided for review. As the clinical documentation provided for review does not meet guideline recommendations for the requested surgical procedure, the reviewer finds medical necessity does not exist for Left Total Hip Replacement w/ 3 Day LOS 27130 and the prior denials are upheld.

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

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE

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)