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Notice of Independent Review Decision

DATE OF REVIEW: 3/09/2015

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MRI of the right hip.

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

M.D. Board Certified in Orthopedic Surgery and sports medicine.

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)

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a male with right hip pain. Limited history available with just one note dated 11/14/14. The patient has "achy hip pain" but otherwise a normal physical exam, including negative provocative maneuvers, and normal gait per the note. Hip injection has not been successful to relieve symptoms. The patient has apparently had a hip arthroscopy at some point and did a few sessions of PT. No X-ray or prior MRI report available. There is no history of a new injury noted. New MRI is requested to evaluate for recurrent labral tear vs DJD/AVN.

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

Per ODG references the requested services "MRI of the right hip " is not medically necessary. With no new injury and essentially a normal physical exam along with the lack of clinical information available, the prior decision to not certify a new hip MRI is upheld. Also with no response to a hip injection the hip joint as a source for the symptoms should be in question. Guidelines recommend an MRI arthrogram for labral tear diagnosis if this is the clinical concern.



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

- 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