

MEDICAL CONTESTED CASE HEARING NO. 14011

**DECISION AND ORDER**

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

**ISSUES**

A contested case hearing was held on September 4, 2013 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the Independent Review Organization (IRO) that Claimant is not entitled to left hip total joint replacement with three day inpatient stay for the compensable injury of (Date of Injury)?

The record was closed on September 24, 2013 when a Hearing Officer-requested copy of Claimant's Exhibits 2 and 3 were provided to complete the record.

**PARTIES PRESENT**

Petitioner/Claimant appeared and was represented by MKW, attorney.  
Respondent/Carrier appeared and was represented by, KP, attorney.

**BACKGROUND INFORMATION**

Claimant was injured in the course and scope of his employment on (Date of Injury), when he tripped and fell. Claimant has had significant conservative care, surgical intervention to his left hip, and is status post left hip arthroscopy on October 27, 2011. Claimant continues to have significant pain and limited range of motion.

Claimant seeks a total left hip replacement. Claimant's provider's request for the procedure was considered by two Utilization Review Officers and the IRO. All concluded that the request did not meet the ODG for the requested treatment.

**Evidence Based Medicine (EBM)**

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence based medicine or, if evidence based medicine is not available, then generally accepted standards of

medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines. The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused, and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. Also, in accordance with Division Rule 133.308(s), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence."

The *ODG* provides the following for hip total joint replacement:

#### Arthroplasty

Recommended when all reasonable conservative measures have been exhausted and other reasonable surgical options have been seriously considered or implemented. (Colorado, 2001) (Dreinhofer, 2006) (Mears, 2002) After THA there is a 96% rate of post-surgical satisfaction. (Mariconda, 2011) One high quality review concluded that in comparison with internal fixation, arthroplasty for the treatment of a displaced femoral neck fracture significantly reduces the risk of revision surgery, but could cause greater infection rates, blood loss, and operative time and possibly an increase in early mortality rates. (Bhandari, 2003) In terms of surgical methods, one study concluded that no significant difference between posterior and direct lateral surgical approach was found. (Jolles, 2004) This study suggests that intervention programs in search of amendable factors to prevent surgical site infections (SSIs) should focus on timely administration of antibiotic prophylaxis. For patients undergoing elective total hip arthroplasty, the

use of antibiotics with long vs short half-lives and broad vs narrow spectrums, timing of antibiotic administration before incision, and duration of antibiotic administration after surgery do not affect the incidence of surgical site infection. Only longer duration of surgery above the 75th percentile is independently associated with increased incidence of surgical site infection after elective total hip arthroplasty. (van Kasteren, 2007) The majority of patients who undergo total joint replacement are able to maintain a moderate level of physical activity, and some maintain very high activity levels. (Bauman, 2007) Patients who undergo total hip replacement for osteoarthritis (OA) report a noticeable long-term improvement in physical functioning, whereas age-matched population controls show a decline in function, according to the results of a recent study. The long-term improvement in the physical functioning of the cases is striking when set against the decline that occurred in controls. These findings add to the accumulating evidence that the benefits for physical functioning are sustained in the long-term and they suggest that those benefits are greatest in the patients who have the most severe radiographic changes of OA before surgery. (Cushnaghan, 2007) Most patients who are physically active prior to THA are able to return to work and exercise postoperatively. (Ries, 1997) (Visuri, 1980) (Gschwend, 2000) (Mallon, 1992) (Powell, 2009) (Jacobs, 2009) (Healy, 2008) Both low back pain and spinal function are improved following total hip replacement surgery. This study demonstrates the clinical benefits of THR on back pain and is the first to clinically validate the hip-spine syndrome. (Ben-Galim, 2007) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense physical therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008) This study showed that total hip replacement is the most successful orthopaedic procedure for relieving chronic pain, and it provides a benchmark against which the efficacy of other procedures can be compared. The study compared the gains in quality of life achieved by total hip replacement, total knee replacement, surgery for spinal stenosis, disc excision for lumbar disc herniation, and arthrodesis for chronic low back pain. Hip replacement reduced pain to levels normal for age, reduced physical functioning to within 75% normal levels, and restored quality of life to virtually normal levels. (Hansson, 2008) The AHRQ has concluded that limited results suggest that femoral neck fracture patients with total hip arthroplasty (THA) have improved patient outcomes over internal fixation (IF). THA had better long-term improvements in pain and mobility than either internal fixation (IF) or hemiarthroplasty. THA is suggested based on patient outcomes for healthy elderly individuals most likely to gain from long-term functional improvements. Hemiarthroplasty should be reserved for patients with inadequate reduction and unlikely to see long-term functional

benefits from surgical treatment. (Butler, 2009) There has been limited evidence in the literature of improved functional outcome with cemented implants versus uncemented, (Rorabeck, 1994) (Laupacis, 1993) (Havelin, 2000) (Malchau, 1993) (Keggi, 1993) (Callaghan, 2004) (Berry, 2002) (Schulte, 1993) (Smith, 1997) (Collis, 1984) although serious cement-related complications have been reported. This recent RCT concluded that both arthroplasties may be used with good results after displaced femoral neck fractures. (Figved, 2009) Patients who take statins after primary total hip arthroplasty (THA) may greatly reduce the risk for revision surgery. (Thillemann, 2010) Prompt surgical fixation is an important first step in the treatment of hip fracture, speeding up subsequent rehabilitation and reducing the risk of limb deformity. (Stott, 2011) Total hip replacement (THR) is generally successful despite comorbid psychological issues, unlike other major surgeries. There was no difference in THR outcomes between the groups that were mentally distressed and not mentally distressed, with overall patient satisfaction rate at five years over 96% in both groups. (Hossain, 2011) Bisphosphonates almost doubled implant survival after total arthroplasty of the knee or hip, according to a large cohort study. (Prieto-Alhambra, 2011)

*Age:* In younger patients, every effort should be made to avoid a hip replacement. Hip replacements work very well for less active patients, but they tend to wear out in younger, more active patients. Therefore, in young patients, a chance may be taken to avoid hip replacement even if there is a high risk of a nonhealing fracture. But reconstructive orthopedic surgeons may sometimes face a shattered femur, defined as a femur that is not reconstructible with conventional methods, and arthroplasty may be indicated. (Lombardi, 2006) Even the very elderly can expect to achieve highly significant pain relief and functional improvement after hip replacement. For patients over 80 years the mortality rate is under 2%, and even in patients over 90, a dramatic increase in mortality after surgery is not observed. The ideal elderly candidate for THA is a healthy community ambulator requiring either a cane or no assist device. (Deirmengian, 2011)

*Metal-on-metal hip replacement:* Not recommended. The FDA has issued an alert with concerns about metal-on-metal (MoM) hip replacement systems, because metal particles may wear off of the device and enter into the space around the implant, or may even get into the bloodstream. (FDA, 2011) New types of hip implants, using metal-on-metal or ceramic-on-ceramic bearings, appear to have no significant advantage over traditional metal on polyethylene or ceramic on polyethylene implants, according to a systematic review. In fact, there is some evidence to suggest that patients who get newer types of implants may be more likely to need revision surgery. (Sedrakyan, 2011) Hundreds of thousands of patients with metal-on-metal hip implants may have been unwittingly exposed to

toxic substances. The health risk arises from implants in which the pelvic cup and the femoral head are both made with a cobalt-chrome alloy, as opposed to other materials such as ceramic or polyethylene. The wear and tear of metal on metal releases metal ions that can seep into local tissue, destroy muscle and bone, and leave patients with long-term disabilities. These metal ions, which may be carcinogenic, also can become blood-borne and spread to the lymph nodes, spleen, liver, and kidneys. FDA cleared the technology through a grandfathered route called 510(k), reasoning that it was basically like other hip replacement devices that were already approved. This process, which is less rigorous than the agency's normal premarketing approval process, did not require any clinical studies. Metal-on-metal hip replacements are still on the market, despite their long-known risks, and the author attributes that fact to "a drive for commercial success unconcerned with patient safety." Hip replacements are one of the great successes of modern medicine, but a combination of inadequate regulation and untrammelled commercialism has caused actual and potential harm for large numbers of patients. (Cohen, 2012)

*Minimally invasive techniques:* Total hip replacement performed through a minimally invasive incision of  $< \text{ or } = 10$  cm compared with a standard incision of 16 cm offers no significant benefit in terms of the rate or ability of patients to mobilize and perform functional tasks necessary for safe discharge. (Lawlor, 2005) The anterior approach on the orthopaedic table is a minimally invasive technique applicable to all primary hip patients. This technique allows accurate and reproducible component positioning and leg-length restoration and does not increase the rate of hip dislocation. (Matta, 2005)

See also Revision total hip arthroplasty.

### **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.

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).  
See also Skilled nursing facility LOS (SNF).

The initial utilization review agent that considered the requested treatment completed a review on January 25, 2013, and noted

[T]his is a 43-year old male who likely has a level of dysplasia. Based upon these findings, he may benefit from hip arthroscopy in addressing the labral pathology as opposed to hip arthroplasty. Ideally, however, joint preservation in someone so young should be considered and favored. I would recommend further consideration of treatment alternatives prior to undergoing any arthroplasty.

After a request for reconsideration, a second utilization review agent completed a review on January 30, 2013, and noted

There was no additional medical documentation noted for the reconsideration. The Guidelines indicate there must be subjective findings such as limited range of motion, night time pain, no relief with conservative care, plus objective findings such as over 50 years of age and body mass index less than 35. Also, imaging must demonstrate osteoarthritis on standing x-rays or impingement about the femoral head. There is no documentation in the radiologist interpretation of those findings other than some mild degenerative osteophytosis of the left hip. The impression was mild degenerative joint disease. It is noted the previous noncertification documented on Magnetic Resonance Imaging had been completed on April 14, 2011, which demonstrated labral tearing and paralabral cyst and this was not provided for review. It is documented the claimant is 5'7 tall and 214 pounds. Based on the calculation, this puts the claimant's body mass index at 33.5. Based upon the medical documentation provided for review and the peer reviewed evidenced based Guidelines the request for reconsideration of left hip total joint replacement and three day inpatient stay would not be medically supported.

The IRO was issued on March 7, 2013. The reviewer outlined Claimant's treatment history and noted

Official radiology report of the left hip x-rays noted some mild degenerative osteophytosis of the left hip, with the impression of mild degenerative joint disease. There is a discrepancy in the official radiology report and the requesting provider interpretation of the radiographs, and no over read or repeat radiographs were documented. Based on the clinical data available for review, it is the opinion of this review that the request for left total hip left hip (sic) total joint

replacement with three day inpatient stay does not meet Official Disability Guidelines criteria, and medical necessity is not established.

Claimant argued that *Appendix D-Documenting Exceptions to the Guidelines* should apply in this case, and that there should be a consideration of whether there is a compelling medical rationale for departing from the Guidelines. Claimant argued that he fell under an exception to the ODG because of the anticipated functional improvement to be brought about by the surgery.

Claimant provided a chart note from JMT, M.D., dated March 22, 2013, where Dr. T noted that he does not agree with the findings of the IRO because of Claimant's significantly limited range of hip motion, and because the x-rays and MRI show loss of articular cartilage and impingement. Dr. T noted that Claimant is steadily becoming disabled due to left hip pain. Also in evidence was a chart note dated January 14, 2013, where Dr. T noted Claimant's treatment, current condition, and recommended for a left hip total joint replacement. Dr. T did not provide evidence of new diagnostics or of an over read of the other diagnostics. Additionally, Claimant did not provide medical evidence that documented how or why the exceptions to the Guidelines should apply.

Carrier observed that Claimant met some of the ODG requirements for the procedure, but argued that Claimant was excluded from the procedure under the ODG because he is too young and too active for the procedure to be indicated. Additionally, the Carrier noted that the diagnostic evidence indicated only mild degenerative joint disease, rather than the ODG required osteoarthritis objectified by x-ray or arthroscopy.

Although Claimant argued that *Appendix D-Documenting Exceptions to the Guidelines* should apply in this case, Claimant failed to present an evidence-based medical opinion from a competent source establishing a compelling medical rationale for departing from the Guidelines. Therefore, Claimant has not met the evidentiary standard required to overcome the IRO decision and the preponderance of the evidence is not contrary to the IRO's determination that the Claimant is not entitled left hip total joint replacement with three day inpatient stay for the compensable injury of (Date of Injury).

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

## **FINDINGS OF FACT**

1. The parties stipulated to the following facts:
  - A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.
  - B. On (Date of Injury), Claimant was the employee of (Employer), Employer.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.
3. Claimant sustained a compensable injury on (Date of Injury).
4. Left hip total joint replacement with three day inpatient stay is not health care reasonably required for the compensable injury of (Date of Injury).

### **CONCLUSIONS OF LAW**

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.
2. Venue is proper in the (City) Field Office.
3. The preponderance of the evidence is not contrary to the decision of the IRO that left hip total joint replacement with three day inpatient stay is not health care reasonably required for the compensable injury of (Date of Injury).

### **DECISION**

Claimant is not entitled to left hip total joint replacement with three day inpatient stay for the compensable injury of (Date of Injury).

### **ORDER**

Carrier is not liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **STANDARD FIRE INSURANCE COMPANY** and the name and address of its registered agent for service of process is:

**CORPORATION SERVICE COMPANY  
211 EAST 7th STREET, SUITE 620  
AUSTIN, TX 78701**

Signed this 2nd day of October, 2013.

Katie Kidd  
Hearing Officer