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Notice of Independent Review Decision

**Date notice sent to all parties:** 03/06/15

**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:**

Board Certified in Orthopedic Surgery

**REVIEW OUTCOME:**

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

☐ Upheld (Agree)

X 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 of the health care services in dispute.

MRI of the right hip - Overturned

**PATIENT CLINICAL HISTORY [SUMMARY]:**

A right hip MR arthrogram was obtained on 08/08/13. There was a small focus of avascular necrosis in the anterior aspect of the femoral head with no subchondral bone collapse or associated fracture. There was an anterosuperior labral tear and no chondral lesions or significant degenerative changes of the right hip. There

were no focal abnormalities of the muscles or tendons about the hip. examined the patient on 08/22/13. His problems were listed as tear of medial cartilage or meniscus of the knee, ACL sprain/strain, dislocation of patella, osteoarthritis of the lower leg, pain in thigh region, and pain in limb. He had undergone left knee surgery on 02/26/04 and right knee surgery on 03/15/11. He had right hip pain from an injury on 04/11/13 when he had a hyperflexion injury to the hip when his right foot got caught in a piece of rebar. He felt a pop in the anterior hip and had therapy and injections with minimal response. He had pain that radiated to the SI joint and coccyx, as well. He walked without a limp. Strength was normal in the lumbar spine and range of motion was also normal. Right hip internal rotation was 20 degrees, external rotation was 40 degrees, and flexion was 100 degrees. Log roll testing was negative and strength was 5/5 in the hip. He did have a positive anterior impingement sign. X-rays of the right hip and showed a central edge angle of 38 degrees with the well maintained joint spaces. There was mild crossover sign and there was a notable small cam lesion identified. The recent MR arthrogram was reviewed. felt the patient had hip impingement, as well as a labral tear and avascular necrosis. He noted it was hard to say if his symptoms had anything to do with the avascular necrosis and/or labral tear. He noted the patient would ultimately require a total hip replacement. An arthroscopic repair of the labrum was noted as a possibility, but noted that it was unlikely the avascular necrosis was traumatic and therefore, the carrier might not necessarily cover it. He would think about his options. On 09/19/13, he returned with continued right hip pain that had worsened over the last couple of weeks. Examination was unchanged. His avascular necrosis was discussed at length, but felt the majority of his symptoms were coming from the labral tear and labral repair was discussed. He noted if the patient required a total hip replacement, it would not be related to his workers' compensation injury due to the avascular necrosis. A left hip core decompression was performed on 11/20/13. On 02/20/14, followed-up with the patient. It was noted he was previously authorized for a right arthroscopy, but he was diagnosed with left hip avascular necrosis and had a core decompression approximately three months prior. He had done well with it and his right hip was more problematic. His pain was in the deep anterior aspect of the groin. Internal rotation was 20 degrees, external rotation was 40 degrees, and flexion was 100 degrees. Log roll was negative and strength was 5/5 in the right hip. Anterior impingement sign was positive. The assessments were hip pain, acetabular labrum tear, and femoral acetabular impingement. noted x-rays that day showed no further displacement or any evidence of subchondral collapse on the femoral head. They discussed a core decompression on the right hip, but noted it would have to be done on his private insurance. still felt the labral tear was the source of his pain and a right hip arthroscopy would be requested. On 04/17/14, the patient was reevaluated. He was two weeks status post right hip arthroscopy with labral repair, acetabuloplasty, and femoroplasty. He was doing well and his portal sites were healing well. He had good range of motion with no pain. Continued therapy and range of motion was recommended. Ibuprofen and light duty were continued. The patient returned on 07/15/14. He had some mild pain in the groin, but stated it was improved from his last visit. His biggest complaint was pain and tingling radiating down the bilateral legs, worse on the

right than the left. He noted this had been present to some extent since the initial injury, but it had recently gotten worse and more frequent. felt clinically he was doing well regarding the right hip. His examination was felt to be consistent with sciatica. A Medrol Dosepak was prescribed, as well as Tramadol. Therapy and home exercises were continued. It was felt his radiating pain was from the lumbar spine. A left hip MR arthrogram was obtained on 09/11/14. There was an anterosuperior labral tear and he was status post placement of cannulated screw in the left femoral head and neck with no evidence of complications. There was chronic avascular necrosis in the anterior superior aspect of the femoral head and neck with no current bone marrow edema or subchondral bone collapse. There were no chondral lesions or significant degenerative changes in the left hip. The patient followed-up once again on 09/16/14. Examination was revealed internal rotation was 20 degrees on the right and 25 on the left, external rotation was 45 degrees bilaterally, and flexion was 100 degrees bilaterally. Anterior impingement sign was positive bilaterally. His left hip MR arthrogram was reviewed. felt some of the patient's left hip pain was a lower back or sacroiliac issue and felt he would benefit from lower back surgery or injections prior to any recommendations for the hip. felt he would be a candidate for arthroscopic decompression and labral repair on the left if he decided to do so. A right hip injection under fluoroscopy was done on 10/31/14. The postoperative diagnosis was right hip pain. The patient returned with bilateral hip pain on 11/11/14. His pain was more on the right than the left. Examination was unchanged. It was noted an intrarticular injection gave no real improvement and was concerned this was more avascular necrosis than the labrum. An MRI was recommended to evaluate the avascular necrosis and to see if there had been any progression or collapse. On 11/24/14, provided a preauthorization request for a right hip MRI. provided an adverse determination for the requested right hip MRI. provided another preauthorization request on 12/31/14 for the right hip MRI. provided another adverse determination on 01/06/15 for the requested right hip MRI. A urine drug screen collected on 02/12/15 revealed Tramadol, which was consistent, but did not reveal Acetaminophen with Codeine, which was inconsistent.

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

This patient has consideration for avascular necrosis at the head of the femur, as well as a labral tear with femoral acetabular impingement based on the documentation reviewed. the requesting provider, is looking for clarity on whether the current condition is due to worsening of the avascular necrosis or a continuation of the known labral tear. Plain film MRI will give information regarding the avascular necrosis or an MR arthrogram (as noted on the last line of the Official Disability Guidelines (ODG) under MRI) would be appropriate to rule out both the labral tear and the avascular necrosis. According to the ODG, Hip & Pelvis Chapter, MRI is the most accepted form of imaging for finding avascular necrosis of the hip and osteonecrosis. (Koo, 1995) (Coombs, 1994) (Cherian, 2003) (Radke, 2003) MRI is both highly sensitive and specific for the detection of many abnormalities involving the hip or surrounding soft tissues and should in

general be the first imaging technique employed following plain films. Therefore, I disagree with the previous reviewers and think based on the clinical material the requested MRI of the right hip is medically necessary and appropriate according to the ODG. The previous adverse determinations should be overturned at this time.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE 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**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **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)**