Phone Number:
(512) 501-3856

True Resolutions Inc.

An Independent Review Organization
500 E 4th St PMB 352
Austin, TX 78701
Email:trueresolutions@irosolutions.com

Fax Number:
(512) 351-7842

Notice of Independent Review Decision

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Left Hip Arthroscopy with Labral Repair

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)

This patient is a male with complaints of left hip pain. On 12/22/14, an MR arthrogram of the left hip revealed left hip osteoarthritis with grade 3-4 superior hip joint chondromalacia. There were superior and anterosuperior labral degenerative changes and a tear suspected. It was noted morphology was compatible with femoral acetabular impingement with a CAM lesion. On 12/12/14, the patient was seen in clinic and it was noted he had an intraarticular injection with 100% improvement for 2 days and then his pain returned. He described pain along the anterior aspect of his left hip. On exam he had pain with range of motion and had a negative straight leg raise. Strength and sensation were preserved. He had pain particularly with Fadir as well as Faber all localized in the anterior aspect of the hip. A left hip arthroscopy was recommended.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 01/13/15, an adverse determination letter was submitted noting the requested left hip arthroscopy with a labral repair was non-certified. It was noted guidelines would support a labral repair on occasion for those who have failed conservative treatment modalities when there is pain associated with the hip labral tear within the first month. It was noted this patient had symptoms for greater than 1 month and had not had objective documentation of failure of conservative treatment modalities. It was noted there was a positive response to prior injections with physical therapy progress notes not being provided for review and therefore the request was non-certified. On 01/23/15, an adverse determination letter was submitted noting there had been inadequate attempts at conservative care. In a peer to peer conversation it was noted the patient was seen 1 month previously and there was a plan to delay surgery until April and therefore the requested left hip arthroscopy with a labral repair was not medically necessary.

Guidelines indicate that repair of labral tears is indicated but there should be early treatment including rest, anti-inflammatory medications, physical therapy, and Cortisone injections. If those treatments fail to alleviate pain associated with the hip labral tear within the 1st month, a hip arthroscopy procedure may be considered. The records indicate the patient has had a labral tear greater than 1 month and there are no physical therapy notes provided to indicate the failure of conservative measures. Therefore, it is the opinion of this reviewer that the request for a left hip arthroscopy with a labral repair is not medically necessary 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 and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)

- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)