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DATE OF REVIEW: 10/18/2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

"Inpatient Stay XX Total Hip Arthroplasty XXXX" for the patient.

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]:

The patient is a XXXX with a date of injury XXXX to the XX hip in a XXXX. XXXX currently is diagnosed with XX hip XX which has been deemed compensable under this claim by court order. XXXX has had XX hip XX with XX and XX bodies. There was grade XX of the hip documented on the operative note of the second surgery. XXXX has been treated with many medications, has had hip injections, and has been treated by pain management for both XXXX hip and low back. According to several pain management notes and a letter from the requesting surgeon's PA the patient has undergone physical therapy as well. These treatments have been ongoing for the past several years, but XXXX continues to have pain in the XX hip. As of a recent office note from the requesting surgeon dated XXXX the patient has pain in the XX groin and buttock. XXXX has an XX and XX of the XX hip. XXXX has severe tenderness to palpation diffusely about the hip. XXXX has limited and painful range of motion of the XX hip. XXXX has an x-ray demonstrating advanced osteoarthritic changes of the XX hip. The current request is for a XX total hip arthroplasty which has been denied previously due to not having done recent formal physical therapy.

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

Per ODG references the requested "XX Total Hip Arthroplasty XXXX" for the patient is medically necessary. The patient has documented XX of XXXX XX hip by x-ray, MRI, and prior arthroscopic surgery. XXXX continues to have pain that limits function despite prior conservative treatments over several years including medications, injections, pain management modalities and physical therapy at some point according to office notes and letters. At this point XXXX meets the criteria for proceeding with XX hip XX, so the current request should be approved.

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 KNOWLEDGE BASE
- ☐ 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