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**Notice of Independent Medical Review Determination**

Dated: 12/2/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/23/2013
Date of Injury:	9/26/2003
IMR Application Received:	8/7/2013
MAXIMUS Case Number:	CM13-0008458

- 1) MAXIMUS Federal Services, Inc. has determined the request for **left hip total arthroplasty versus hip resurfacing arthroplasty is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy times 12 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **medical clearance is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **MRI cervical spine is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **right wrist splint is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **right carpal tunnel release is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **neurology consultation is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for **epidural steroid injection is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/7/2013 disputing the Utilization Review Denial dated 7/23/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/6/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **left hip total arthroplasty versus hip resurfacing arthroplasty is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy times 12 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **medical clearance is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **MRI cervical spine is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **right wrist splint is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **right carpal tunnel release is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **neurology consultation is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for **epidural steroid injection is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The Expert Reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and treatments and/or services at issue.

### **Expert Reviewer Case Summary:**

This claimant is a 58-year-old male with multiple complaints of pain. On 04/05/2012, he was seen by a clinic. At that time, it was noted he had progressive symptoms of pain to his left hip associated with post-traumatic degenerative joint disease. On exam, he walked with an antalgic gait with limited range of motion. Forward flexion was rated at 95 degrees, internal rotation 20 degrees, external rotation 40 degrees, and abduction was 35 degrees with pain at the extreme ranges of motion. X-rays apparently showed

severe degenerative changes with complete obliteration of the joint space, superolateral migration, and lateral extrusion and osteophyte formation. The assessment was left hip post-traumatic degenerative joint disease. On 07/25/2013, a utilization review determination non-certified the request including left total hip arthroplasty versus hip resurfacing arthroplasty, postoperative PT x12, request for preoperative medical clearance, request for MRI of the cervical spine, request for right wrist splint, request for right carpal tunnel release, request for neurological consultation, and request for epidural steroid injection. On 08/19/2013, a handwritten Primary Treating Physician's Progress Note indicates the claimant had increased pain to his neck, knee, and left hip. It was reported that he had positive Spurling's sign and decreased sensation at C6-7 and had a positive painful flexion and extension, but had a negative Hoffmann's sign. He had impingement of the left hip. On 09/03/2013, patient reassessment was submitted indicating physical exam revealed severe pain overlying the left femoral head and pain over the bursa. There was pain on internal and external rotation in flexion. Previous MRI did not indicate avascular necrosis and did not indicate joint effusion. However, it did indicate mild arthritic changes. The plan was for left hip injection under fluoroscopic guidance.

#### **Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for left hip total arthroplasty versus hip resurfacing arthroplasty:**

##### Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), hip section, hand/wrist section, and cervical spine section, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Initial Approaches to Treatment (American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 3) pg. 43-47, Initial Approaches to Treatment, which is a part of the MTUS and on the Official Disability Guidelines (ODG), hip and pelvis chapter, which is not a part of the MTUS.

##### Rationale for the Decision:

This request is for a left hip total arthroplasty versus hip resurfacing arthroplasty. A review of the records indicates a 04/05/2012 clinical note by a provider apparently indicates that x-rays showed degenerative changes which were present with complete obliteration of the joint space, with superolateral migration and lateral extrusion and osteophyte formation. The specific joint imaged was not documented on that exam however. Additionally, the 09/03/2013 progress by a

provider indicates that a previous MRI in 2010 did not indicate avascular necrosis and did not indicate joint effusion, but did indicate "mild arthritic changes." MTUS/ACOEM do not specifically address this issue. They do indicate that position comfort can be achieved in several ways such as physical methods, rest, immobilization, activity limitations, medication, tests, and surgery. Official Disability Guidelines, Hip and Pelvis Chapter goes further indicating an arthroplasty is recommended when all reasonable conservative measures have been exhausted and other reasonable surgical options have been seriously considered or implemented. Official Disability Guidelines further indicates there should be subjective clinical findings such as limited range of motion or night time joint pain or no pain with conservative care, objective findings such as the patient being over 50 years of age with a body mass index of less than 35, plus imaging studies demonstrating osteoarthritis on standing x-ray or arthroscopy. The records are not conclusive as to whether this employee has significant arthritis of the left hip. The records do not indicate a failure of conservative measures as a left hip injection under fluoroscopic control was planned as late as 09/03/2013 by a provider. As such, rationale for approving a left hip total arthroplasty versus hip resurfacing arthroplasty has not been demonstrated and this request. **The request for left hip total arthroplasty versus hip resurfacing arthroplasty is not medically necessary and appropriate.**

**2) Regarding the request for post-operative physical therapy times 12:**

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**3) Regarding the request for medical clearance:**

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**4) Regarding the request for MRI cervical spine:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 8) pgs. 177-179, which is a part of the MTUS.

Rationale for the Decision:

The medical records provided for review indicate that on 08/19/2013, the employee had decreased sensation at Cervical (C) 6-7 with positive Spurling's sign. MTUS/ACOEM Guidelines indicate that criteria for ordering imaging studies would be emergence of a red flag, physiologic evidence of tissue insult or neurological dysfunction, failure to progress in a strengthening program intended

to avoid surgery, or clarification of the anatomy prior to invasive procedures. The positive Spurling's sign and decreased sensation in a C6 distribution are physiologic evidence of tissue insult or neurological dysfunction and is a red flag for this employee. **The request for MRI cervical spine is medically necessary and appropriate.**

**5) Regarding the request for right wrist splint:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 11) pgs. 265-266, which is a part of the MTUS.

Rationale for the Decision:

MTUS/ACOEM Guidelines indicate that when treating with a splint in carpal tunnel syndrome, scientific evidence supports the efficacy of neutral wrist splints, and splinting should be used at night and may be used during the day depending on the activity.

The medical records provided for review indicate that the most recent clinical notes dated 08/19/2013 fail to describe specific physical findings attributable to carpal tunnel syndrome. There was a lack of documentation of a positive Tinel's sign or positive Phalen's sign or thenar atrophy. The request is not specific to which hand is to be splinted. **The request for right wrist splint is not medically necessary and appropriate.**

**6) Regarding the request for right carpal tunnel release:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 11) pgs. 270-271, which is a part of the MTUS.

Rationale for the Decision:

The medical records provided for review fail to describe significant current conservative care attributable to the right for carpal tunnel syndrome (CTS). The medical records provided for review do not describe a positive Tinel's sign or positive Phalen's sign or thenar atrophy. The medical records provided for review also do not describe this employee being prescribed a wrist splint or having an injection to the carpal tunnel. MTUS/ACOEM Guidelines indicates surgical decompression of the median nerve usually relieves CTS symptoms. Surgical considerations depend on a confirmed diagnosis of the presenting hand or wrist

complaint. MTUS/ACOEM Guidelines indicate there should be failure to respond to conservative management including work site modifications, and there should be clear clinical and special study evidence of a lesion that has been shown to benefit in both the short-term and long-term from surgical intervention. Electrodiagnostic studies have not been provided for this review to objectively document that this employee has carpal tunnel syndrome. As such, the rationale for proceeding with this surgical intervention at this time has not been demonstrated by the records provided. **The request for right carpal tunnel release is not medically necessary and appropriate.**

**7) Regarding the request for neurology consultation:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 8) pgs. 165-166, which is a part of the MTUS.

Rationale for the Decision:

MTUS/ACOEM Guidelines indicate that in the absence of red flags, imaging and other tests are not usually helpful during the first 4 weeks of neck and upper back symptoms and primary care or occupational physicians can effectively manage acute and subacute neck and upper back problems conservatively in the absence of red flags.

The medical records provided for review indicate that this employee does have a positive Spurling's sign on exam. However, there is a lack of correlation between physical exam and imaging studies. The MRI is now being considered medically necessary. At this time, a referral should be pending further evaluation of the MRI of the cervical spine. **The request for neurology consultation is not medically necessary and appropriate.**

**8) Regarding the request for epidural steroid injection:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 8) pg. 173, which is a part of the MTUS and the Chronic Pain Medical Treatment Guidelines, Epidural Steroid Injections (ESIs), page 46, which is a part of the MTUS.

Rationale for the Decision:

MTUS/ACOEM Guidelines indicate that invasive techniques have no proven benefit in treating acute upper back symptoms. MTUS Chronic Pain Medical Treatment Guidelines indicate radiculopathy must be documented by physical exam and corroborated by imaging studies and/or electrodiagnostic studies. The medical records provided for review indicate that electrodiagnostic studies have not been provided for this review at this time, and the imaging studies have not been provided for this review to objectively document cervical spine radiculopathy. As such, the rationale for proceeding with this request at this time has not been demonstrated by the records. **The request for epidural steroid injection is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

/ejf

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