

<b>Case Number:</b>	CM14-0079108		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	02/08/2012
<b>Decision Date:</b>	08/15/2014	<b>UR Denial Date:</b>	05/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 44-year-old female correctional officer sustained an industrial injury on 2/8/12. Injury occurred when she was running to an alarm, lost her footing and fell. She underwent a right hip arthroscopy with labral repair, femoroplasty, and capsular repair on 4/5/13. She continued to have significant pain and limitation of motion post-operatively. She failed conservative treatments. The 4/1/14 orthopedic report cited on-going right hip pain, primarily anterior, which was worse with sitting, standing and walking. The patient used a cane and had an antalgic gait. Range of motion testing documented flexion 7, internal rotation 10, external rotation 20, and abduction 30 degrees, with pain in all motions. There was tenderness over the rectus and greater trochanter. Strength was 4+/5. Internal impingement, lateral impingement, Faber, log roll and dial tests were positive. The treating physician noted her hip was very irritable and stiff and opined this may be due to adhesions. Revision arthroscopy was recommended to address lysis of adhesions, contour the femoral neck to avoid further impingement, and for capsular release. The 5/6/14 utilization review certified a request for right hip arthroscopy revision and capsular release. The request for a hip brace was denied as there was no evidence of instability and post-operative motion would start right away. The ice unit was denied as there was no clear indication for continuous flow cryotherapy over simple cold packs. Percocet was denied as Norco was requested and certified for #90, medical necessity of a second pain medication was not established. The request for post-operative physical therapy for 24 sessions was partially approved for 12 sessions.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Hip brace:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Jaime Edelstein et al. Post-operative guidelines following hip arthroscopy *Curr Rev Musculoskelet Med.* Mar 2012; 5(1): 15-23.

**Decision rationale:** The California MTUS, Official Disability Guidelines and National Guideline Clearinghouse do not provide recommendations for hip bracing post-operatively. Peer-reviewed medical literature stated that hip bracing is optional during post-op rehabilitation of patients following hip arthroscopy involving femoral osteochondroplasty. Guideline criteria have been met. This request for hip brace is consistent with medical practice for the requested surgery and at provider discretion. Therefore, this request for a hip brace is medically necessary.

**Ice unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis, Cryotherapy.

**Decision rationale:** The California MTUS is silent regarding continuous flow cryotherapy units. The Official Disability Guidelines recommend continuous flow cryotherapy as an option limited to 7 days post-operative use. The use of a cold therapy unit could be reasonable for 7 days use post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request for one ice unit is not medically necessary and appropriate.

**Post-op physical therapy x 24 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** The California Post-Surgical Treatment Guidelines relative to hip surgeries generally suggest a course of 24 post-operative visits over 10 weeks during the 4-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. The 5/6/14

utilization review recommended partial certification of 12 post-operative physical therapy visits consistent with guidelines. There is no compelling reason submitted to support the medical necessity of additional care. Therefore, this request for post-op physical therapy x 24 sessions is not medically necessary and appropriate.

**Percocet:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Page(s): 92.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use. Opioids, specific drug list Page(s): 76-80, 92.

**Decision rationale:** The California MTUS indicate that opioids, such as Percocet (oxycodone/acetaminophen), are recommended for moderate to moderately severe pain. In general, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Records indicate that Norco was also requested for post-operative use and had been approved for #90. The patient is noted to also be taking Dilaudid. There is no compelling reason to support the medical necessity of an additional opioid analgesic. The current request additionally lacks sufficient prescribing information to establish medically necessary. Therefore, this request for Percocet is not medically necessary and appropriate.