

Case Number:	CM14-0194489		
Date Assigned:	12/02/2014	Date of Injury:	04/09/2014
Decision Date:	02/06/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/20/2014

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, has a subspecialty in Sports Medicine 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 is a male injured worker with an injury date of 04/09/2014. The documentation described the mechanism of injury to involve significant pivoting, and twisting accompanied by strenuous pushing of a medication cart, repetitively. An orthopedic follow up visit dated 09/16/2014 reported the injured worker with a history of right hip replacement approximately 14 years prior. He continued with complaint of right shoulder and left hip discomfort. He has undergone some physical therapy, uses a cane and also takes Ibuprofen with some effect. He is diagnosed with left hip osteoarthritis with the recommendation of total surgical intervention. Radiography study performed on 07/14/2014 revealed femoroacetabular impingement on the left and bilateral proximal hamstrings tendonitis. A request for services was made on 10/21/2014, asking for a total hip replacement, assisting surgeon, walker, bedside commode and 8 physical therapy sessions. The Utilization Review denied the request as not meeting medical necessity requirements.

IMR ISSUES, DECISIONS AND RATIONALES

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

Total Hip Replacement Inpatient Stay: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, Hospital length of stay (LOS).

Decision rationale: The request for total hip replacement inpatient stay is not medically necessary. According to the Official Disability Guidelines, the best practice for hospital length of stay is 3 days. The clinical documentation submitted for review did not note that this injured worker had a total hip replacement nor was then an approved surgical procedure for the hip. Consequently, the request is not supported by the evidence based guidelines. As such, the request for total hip replacement inpatient stay is not medically necessary.

Walker: 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), Knee and Leg chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: According to the Official Disability Guidelines, walking aids are recommended. The clinical documentation submitted for review did not indicate a rationale for the requested service nor that the injured worker had undergone a recent surgery or was approved for projected surgery. Consequently, the request is not supported by the evidence based guidelines. As such, the request for walker is not medically necessary.

Beside Commode: 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) Knee & Leg, Durable medical equipment (DME).

Decision rationale: According to the Official Disability Guidelines, bedside commodes are recommended if the injured worker is bed or room confined. The clinical documentation submitted for review did not indicate a rationale for the requested service nor that the injured worker had undergone a recent surgery or was approved for projected surgery or was bed-/room-confined. Consequently, the request is not supported by the evidence based guidelines. As such, the request for bedside commode is not medically necessary.

8 Physical Therapy Visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request for 8 physical therapy visits is not medically necessary. According to the California MTUS Guidelines, physical medicine is recommended to restore function such as range of motion and motor strength. The clinical documentation submitted for review did not indicate the injured worker's current functional deficits. Additionally, the request does not specify which body region the physical therapy is to benefit. Consequently, the request is not supported by the evidence based guidelines. As such, the request for 8 physical therapy visits is not medically necessary.