

<b>Case Number:</b>	CM14-0206440		
<b>Date Assigned:</b>	12/18/2014	<b>Date of Injury:</b>	05/14/2012
<b>Decision Date:</b>	03/16/2015	<b>UR Denial Date:</b>	11/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### CLINICAL CASE SUMMARY

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

The injured worker is a 71-year-old male who reported injury on 05/14/2012. The mechanism of injury was not submitted for review. The injured worker has a diagnosis of left hip osteoarthritis, status post right total hip arthroplasty with a metal on metal implant. Past medical treatment consisted of medication therapy; medications were documented in the report. It was noted in the progress note that the injured worker underwent x-rays of the left hip, which revealed narrowing of the hip joint space. The x-rays were not submitted for review. On 11/04/2014, the patient was seen on a follow-up appointment. Physical examination noted that there were no areas of tenderness. There were no obvious spasms detected, and there was no tenderness over the greater trochanter. Range of motion of the left hip revealed a flexion of 100 degrees, external rotation 20 degrees, internal rotation 0 degrees, abduction of 30 degrees, and adduction of 10 degrees. Hip abduction weakness was at 4-/5 on the left. The injured worker had full sensation to light touch and pinprick throughout the lower extremities with good pulses noted, being 2+/4+ for the dorsalis pedis and posterior tibia. There was a negative Ober test, impingement test, instability to stress test, and Stinchfield test. Medications included prednisone, losartan, HCTZ, aspirin, and gemfibrozil. The medical treatment plan is for the injured worker to undergo left total hip arthroplasty. The rationale and Request for Authorization forms were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1-3 days length of stay: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Front wheel walker: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**3 in 1 commode: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**12 physical therapy to the left hip: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre op testing labs: 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), Low Back, Preoperative lab testing and pre operative medical clearance

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Medical clearance:** 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), Low Back, Preoperative lab testing and pre operative medical clearance

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Left total hip arthroplasty:** 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), Hip & Pelvis and Arthroplasty

**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, Arthroplasty.

**Decision rationale:** The request for left total hip arthroplasty is not medically necessary. Official Disability Guidelines state that arthroplasty is recommended when all reasonable conservative measures have been exhausted, and other reasonable surgical options have been seriously considered or implemented. The guidelines indicate that there should be trialed and failed conservative care to include supervised physical therapy and home exercise rehab; medications; and steroid injections. There should also be subjective and objective clinical findings to include limited range of motion, nighttime joint pain, no pain relief with conservative care over the age of 50, and with a body index mass of less than 35%. The guidelines also state that there should be imaging clinical findings of osteoarthritis on standing x-ray or arthroscopy. The submitted documentation indicated that the injured worker had limited range of motion. There was no indication of nighttime joint pain, nor was there any evidence of the injured worker having tried and failed conservative treatment. Additionally, the submitted documentation did not indicate whether or not the injured worker had a body mass index of less than 35. Furthermore, it was noted in the progress note that the injured worker underwent an x-ray of the hip; however, the x-rays were not submitted for review. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.