

Case Number:	CM15-0026327		
Date Assigned:	02/19/2015	Date of Injury:	09/16/2011
Decision Date:	03/31/2015	UR Denial Date:	02/06/2015
Priority:	Standard	Application Received:	02/11/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 49-year-old female, who sustained an industrial injury on 9/16/11. Injury occurred when she was lifting and dragging a bag with difficulty, with onset of right hip pain. The 10/11/12 right hip MRI impression documented a mild degree of fluid within the hip joint which could indicate synovitis or effusion. A labral tear could not be ruled-out. There were no other bony, joint, or soft tissue abnormalities visualized. She was diagnosed with hip impingement with symptomatic labral tear. She underwent right hip arthroscopy with acetabular takedown, labral repair, and femoral neck resection on 5/6/13. The operative report documented a post-op diagnosis of right hip pincer impingement with labral tearing, and Cam impingement. The 12/22/14 treating physician report cited constant grade 5/10 low back pain radiating to the right leg, and constant grade 8/10 right hip pain, partially relieved with oral and topical medications. The diagnosis was lumbar sprain/strain and status post right hip labral surgery. The treatment plan included a prescription for Ambien and Oxycodone, and Xanax, Terocin patches, and Methoderm gel were dispensed. The 12/22/14 orthopedic report documented a Synvisc One injection to the right hip in November with no symptom relief. The patient had tried anti-inflammatories, rest, and activity modification with no improvement. Physical exam documented pain with flexion and internal rotation. Right hip range of motion testing documented flexion 110 degrees, internal rotation 5 degrees, and external rotation 40 degrees. Faber sign was 3 fists from the table on the right and 2 on the left. The diagnosis was right hip osteoarthritis. The treatment plan recommended right total hip arthroplasty with associated surgical requests. On 2/6/15, utilization review non-certified a total hip arthroplasty, ice machine, post-operative home

physical therapy x4, and post-operative outpatient physical therapy x12, noting that as the surgery was not recommended as medically necessary, the postoperative ice machine and physical therapy were also not medically necessary. The rationale documented no x-ray evidence of osteoarthritis to support the medical necessity of surgery. The MTUS Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines (ODG) were cited. On 2/11/15, the injured worker submitted an application for IMR.

IMR ISSUES, DECISIONS AND RATIONALES

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

Total Hip Arthroplasty: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip & Pelvis (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Hip and Pelvis: Arthroplasty

Decision rationale: The California Medical Treatment Utilization Schedule does not provide recommendations for hip surgery. The Official Disability Guidelines recommend total hip arthroplasty when all reasonable conservative measures have been exhausted and other reasonable surgical options have been seriously considered or implemented. Criteria include exercise therapy (supervised physical therapy and/or home rehab exercises) and medications (unless contraindicated non-steroidal anti-inflammatory drugs or steroid injection). Subjective findings should include limited range of motion, or night-time joint pain, or no pain relief with conservative care. Objective findings should include over 50 years of age and body mass index less than 35. Imaging findings of osteoarthritis on standing x-rays or arthroscopy are required. Guideline criteria have not been met. The patient presents with significant right hip pain and loss of range of motion. The 5/16/13 operative report did not document findings of significant osteoarthritis. There are no standing x-ray findings documented in the provided records. The patient is currently not over 50 years of age. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including physical therapy or exercise, and failure has not been submitted. Therefore, this request is not medically necessary.

Associated surgical service: Ice Machine: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Hip and Pelvis: Cryotherapy Knee and Leg: Continuous flow cryotherapy

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

Post-Operative Home Physical Therapy x 4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51, Postsurgical Treatment Guidelines Page(s): 23.

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

Post-Operative Outpatient Physical Therapy x 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 23.

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