

<b>Case Number:</b>	CM15-0064996		
<b>Date Assigned:</b>	04/21/2015	<b>Date of Injury:</b>	09/09/1994
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	04/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/06/2015

### 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: New York  
Certification(s)/Specialty: Neurological 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 65 year old female who sustained an industrial injury on 9/9/94 from a trip causing her to land on her hands and knees. She experienced immediate pain throughout her back, knees and hands. She initially had x-rays, medication and returned to work with regular duties. Her pain persisted and she was referred to an orthopedic provider who ordered an MRI of the neck, back, hips, and knees. She currently complains of constant bilateral hip pain. Due to the pain she is unable to perform activities of daily living. Medications are Xanax, Soma, Tagamet, Cymbalta, Neurontin, Lidoderm patch, Nexium, Norco, Motrin, Oxycodone, Oxycontin, Roxicodone, Zanaflex, and Trazadone. Diagnoses include necrosis left femoral head; status post left hip resection with residual Girdlestone procedure hip resection; severe degenerative arthritis right hip; status post thoracic spinal cord stimulator removal (10/13/11); status post L1-L3 revision decompression, fusion and fixation (3/31/11); status post lumbar laminectomy (1979); status post revision decompression and fusion at L4-S1 (1995); removal of lumbar hardware (1998); status post anterior lumbar fusion L3 to S1 with posterior fusion L3-4 (2002). Treatments to date include cold therapy unit, medications, injection into both knees, spinal cord stimulator, and physical therapy. Treatments proved somewhat effective in reducing pain. Diagnostic included MRI of hips; x-ray of bilateral hips were abnormal; MRI lumbar spine (10/11/10). In the progress note dated 3/4/15 the treating provider's plan of care includes a request for right total hip arthroplasty; three days in acute hospital and minimum two weeks rehabilitation at an acute care hospital; chest x-ray; electrocardiogram; labs; cold therapy unit; walker; 3-1 commode; post-operative physical therapy, 12 sessions; x-rays for templating the prosthesis.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Right 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip replacement chapter-Arthroplasty Infectious Disease-Bone and joint infections.

**Decision rationale:** The ODG guidelines do recommend hip arthroplasty but the documentation indicates this patient was seen by five orthopedic surgeons who felt the risks of surgery were too high. She had the left hip replacement and then the hardware had to be removed two weeks later and she underwent extended antibiotic treatment and then intermittently ran a fever which was worrisome for smouldering residual infection. The guidelines note that removal of all necrotic and infected tissue should be debrided and the C-reactive protein normalized. Documentation does not show this has been done. A contraindication for hip replacement is present for infection elsewhere in the body. The guidelines recommend that implantation with new prosthesis can proceed if there is no sign of residual infection. Documentation does not provide this proof. The requested treatment: Right Total Hip Arthroplasty is not medically necessary and appropriate.

### **Associated Surgical Service: Chest X-ray: 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.

### **Associated Surgical Service: EKG: 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.

### **Associated Surgical Service: Labs: CBC, CMP, PT, PTT, UA: 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.

**Associated Surgical Service: 3 Day Inpatient 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.

**2 Weeks in Rehab Hospital Post-operatively:** 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.

**Associated Surgical Service: Cold therapy unit:** Upheld

**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 Since the requested treatment: Right Total Hip Arthroplasty is NOT Medically necessary and appropriate, then the Requested Treatment: Associated Surgical Service: Cold therapy unit is NOT Medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: Right Total Hip Arthroplasty is NOT Medically necessary and appropriate, then the Requested Treatment: Associated Surgical Service: Cold therapy unit is NOT Medically necessary and appropriate.

**Associated Surgical Service: 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.

**Associated Surgical Service: 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 Postoperative Physical Therapy sessions:** 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.

**Associated Surgical Service: X-Rays 2v & AP Pelvis:** 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.