

<b>Case Number:</b>	CM15-0075455		
<b>Date Assigned:</b>	04/28/2015	<b>Date of Injury:</b>	01/29/2010
<b>Decision Date:</b>	08/04/2015	<b>UR Denial Date:</b>	04/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/20/2015

### 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: California  
 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 50 year old female, who sustained an industrial injury on January 29, 2010. She reported chronic low back pain and left hip pain secondary to injury of the labrum. The injured worker was diagnosed as having osteoarthritis of the pelvis and herniated lumbar disc. Treatment to date has included radiographic imaging, diagnostic studies, physical therapy, facet injections, medications and work restrictions. Currently, the injured worker complains of chronic low back pain and left hip pain. The injured worker reported an industrial injury in 2010, resulting in the above noted pain. She was treated conservatively without complete resolution of the pain. Evaluation on October 28, 2014, revealed continued pain as noted. Surgical intervention of the left hip was requested. Between that time and when the procedure could be requested physical therapy, medications and facet joint injection were recommended. Evaluation on January 12, 2015, revealed continued pain as noted and pain in the right knee. Magnetic resonance image of the right knee and aquatic therapy was recommended. Surgical intervention of the hip, post-operative physical therapy, medical equipment and an assistant surgeon were requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Total left 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), Hips and Pelvis Chapter, Arthroplasty.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of total hip arthroplasty. According to ODG, Hip and Pelvis, arthroplasty criteria described conservative care and objective findings. These must include either limited range of motion or night time joint pain. Objective findings include age greater than 50 years and BMI of less than 35. In addition there must be imaging findings of osteoarthritis on standing radiographs. In this case the cited clinic note does not demonstrate conservative care has been attempted and there is no documented BMI. Therefore the determination is for not medically necessary as guideline criteria has not been satisfied.

**Associated surgical service: 1-3 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis, Hospital Length of Stay.

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

**Associated surgical service: Assistant surgeon:** 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.

**Post- operative Physical therapy 3x4:** 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: Raised commode:** 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 ODG Knee and Leg, DME toilet items.

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

**Associated surgical service: Shower stool:** 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 ODG Knee and Leg, DME toilet items.

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

**Associated surgical service: 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.

**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 Official Disability Guidelines (ODG) Knee and Leg, Continuous flow cryotherapy.

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

