

<b>Case Number:</b>	CM14-0170689		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	06/17/2006
<b>Decision Date:</b>	12/18/2014	<b>UR Denial Date:</b>	10/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2014

### 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 Surgeon and is licensed to practice in Texas. 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:

The injured worker is a 56-year-old female who reported an injury on 08/29/2013. The mechanism of injury involved a fall. The current diagnosis is end stage left hip osteoarthritis. The injured worker presented on 09/30/2014 with complaints of left hip pain and left shoulder pain. Previous conservative treatment includes anti-inflammatory medication and physical therapy. Physical examination revealed painful range of motion with 90 degree flexion, 20 degree internal rotation, 30 degree external rotation, 40 degree abduction, an antalgic gait and mild tenderness. X-rays of the left hip revealed joint space narrowing, subchondral sclerosis and osteophyte formation. It is noted that the injured worker has failed to respond to conservative treatment with anti-inflammatory medication and activity modification. A left total hip replacement was requested at that time. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**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, Hip and Pelvis

**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 Chapter, Arthroplasty.

**Decision rationale:** The Official Disability Guidelines state prior to a hip arthroplasty, there should be documentation of conservative treatment in the form of exercise therapy and medication or steroid injection. There should be evidence of limited range of motion, night time joint pain, and a failure of conservative treatment. Patients should be over 50 years of age with a BMI of less than 35. There should be documentation of osteoarthritis on standing x-ray or on a previous arthroscopy report. As per the documentation submitted, the injured worker has been previously treated with 4 to 5 physical therapy sessions and anti-inflammatory medication. Physical examination does reveal limited range of motion and tenderness to palpation. X-rays obtained in the office indicated joint space narrowing with subchondral sclerosis and osteophyte formation. However, the injured worker's BMI was not provided for this review. Therefore, the injured worker does not currently meet criteria as outlined by the Official Disability Guidelines. As such, the request is not medically appropriate at this time.

**Associated surgical service: Medical clearance:** 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.