MAXIMUS Federal Services

Case Number:	CM14-0213026		
Date Assigned:	12/30/2014	Date of Injury:	03/21/2014
Decision Date:	03/10/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/19/2014

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 31-year-old female who reported injury on 03/21/2014. The mechanism of injury was the injured worker fell on her left hip while working. Surgical history was not provided. Diagnostic studies included x-rays on 10/01/2014, which documented the injured worker had an anterior center edge angle of 30 degrees and an alpha angle of 68 degrees. There were 2 views of the lumbar spine, and there was no evidence of fracture. The injured worker underwent 14 sessions of physical therapy without benefit. The injured worker had a cortisone injection, which resulted in less tightness of the hip. The documentation of 10/01/2014 revealed the injured worker had pain within the groin, as well as the lateral aspect of the hip. Prior therapies included cortisone and a Medrol Dosepak and physical therapy without improvement. The physical examination revealed full range of motion of the lumbar spine in forward flexion, extension and lateral rotation. The injured worker had a positive impingement sign on the left hip and was tender over the lateral aspect of the left hip. The treatment plan included an MR arthrogram of the left hip. The MRI of 10/20/2014 revealed the injured worker had a labral tear. The injured worker had a 10 mm length contrast opacified linear tear of the anterior hip labrum at the 3 o'clock position. The left hip alpha angle was 54 degrees, and the injured worker had a left proximal femoral diaphyseal enchondroma or low grade chondral lesion without aggressive MR imaging features. The lesion was 2.5x1.7x1.2 cm. The documentation of 11/05/2014 revealed the injured worker had tried 3 months of physical therapy without benefit. The physical examination revealed a positive impingement sign on the left. The treatment plan included surgical intervention. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-Op VPULSE DVT/Cold Contrast Therapy System: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, continuous flow cryotherapy, Hip Chapter, Venous thrombosis.

Decision rationale: The Official Disability Guidelines indicate that injured workers should be evaluated and those who are identified as being at high risk of developing a venous thrombosis should be provided prophylactic measures, such as consideration for anticoagulation therapy. There was a lack of documentation indicating the injured worker had been assessed and found to be at high risk. Additionally, the Official Disability Guidelines indicate that continuous flow cryotherapy is recommended for up to 7 days postoperatively. The documentation failed to provide a rational for a dual component unit which included DVT and cold contrast therapy. The request as submitted additionally failed to provide documentation of the duration of use and whether the unit was for rental or purchase. Given the above, the request for Post-Op VPULSE DVT/Cold Contrast Therapy System is not medically necessary.

Post-Op continuous passive motion: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip Chapter, Continuous Flow Cryotherapy.

Decision rationale: The Official Disability Guidelines indicate continuous passive motion is recommended postoperatively in the acute hospital setting for 4 to 10 days for a total hip arthroplasty and for home use for up to 17 days while the injured worker is at risk of stiff hip or was unable to bear weight. Under conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total hip arthroplasty or revision, this may be considered. The clinical documentation submitted for review failed to indicate the injured worker had undergone a hip arthroplasty. Additionally, the request as submitted failed to indicate the duration of use and whether the unit was for rental or purchase and the body part to be treated. Given the above and the lack of documentation, the request for Post-Op continuous passive motion is not medically necessary.