

<b>Case Number:</b>	CM15-0063199		
<b>Date Assigned:</b>	04/10/2015	<b>Date of Injury:</b>	08/16/2013
<b>Decision Date:</b>	06/16/2015	<b>UR Denial Date:</b>	03/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2015

### 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, 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 50 year old female, who sustained an industrial injury on August 16, 2013. The mechanism of injury involved a fall. Diagnoses have included left hip fracture, cervical spine strain/sprain, lumbar spine strain/sprain, chronic regional pain syndrome, and urinary incontinence. Treatment to date has included medications, physical therapy, and left hip surgery, use of a walker, imaging studies, and diagnostic testing. A progress note dated February 14, 2015 indicates a chief complaint of lower back pain radiating to the legs, knee pain, and left hip pain. The injured worker had a surgical history of a percutaneous pinning of a left hip fracture on 08/17/2013. Following the surgery, the injured worker was partial weight bearing on the left side, which aggravated the right side due to compensation. The injured worker utilized a wheeled walker for ambulation assistance. It was also noted that the injured worker had a history of chronic urinary incontinence and multiple spine surgeries with radicular symptoms. The injured worker noted significant pain involving the left hip with hypersensitivity over the area of hardware. The injured worker had radicular symptoms radiating into the right knee. Upon examination, there was limited range of motion secondary to pain with symptoms of bursitis type pain. The injured worker demonstrated an antalgic gait. There was significant pain over the trochanteric bursa and prominent palpable screws. There was limited range of motion of the bilateral knees with crepitus, grinding, and instability on the right. Positive McMurray's sign was also noted on the right. There was limited range of motion of the right knee from 5 to 120 degrees, and on the left from 5 to 130 degrees. Treatment recommendations at that time included removal of the prominent screws with bone grafting.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Outpatient Removal Prominent Screws and Bone Grafting to the Left Hip: 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); Hip and Pelvis Chapter.

**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, Hardware implant removal (fracture fixation).

**Decision rationale:** The Official Disability Guidelines do not recommend the routine removal of hardware implanted for a fracture fixation, except in the case of broken hardware or persistent pain, after ruling out other causes of pain such as an infection or nonunion. In this case, the hip fracture is shown to be healed. The physician indicated the screws may be causing the injured worker's symptoms, and a removal of the screws may be beneficial. However, the injured worker also has objective evidence of significant pain over the trochanteric bursa. The injured worker was given a series of injections for bursitis. The injured worker's response to the procedure should be documented prior to the request for a surgical intervention. The request as submitted also includes bone grafting for the left hip; however, there was no further information provided to support the necessity for bone grafting. Given the above, the request is not medically necessary at this time.

**Associated 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 Service: 2-D Echo Carlile: 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 Service: Carotid Duplex: 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 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.

**Pre-Operative Labs: CBC, CMP: 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.

**Pre-Operative Labs: PT/PTT: 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.

**Pre-Operative Labs: TSH Lipid/Thyroid Panel: 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.

**Pre-Operative Labs: 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.