

Case Number:	CM15-0094084		
Date Assigned:	05/20/2015	Date of Injury:	03/14/2011
Decision Date:	06/30/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	05/15/2015

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: Illinois, California, Texas
 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 57-year-old male who sustained an industrial injury on 3/14/11. Injury occurred relative to carrying paramedic bags while on call. Records documented that right hip x-rays showed almost an auto-fusion and shortening of about 7 mm, with impression of severe right hip osteoarthritis. The 1/16/15 treating physician report cited increased right hip and anteromedial thigh pain and weakness. Medications included Mobic, Flexeril, and Tylenol #3. The injured worker was 5'7 tall and weighed 178 pounds. He ambulated without the use of an assistive device. He walked with a Trendelenburg gait. Hip flexion was 70 degrees, abduction was 20 degrees. He had no internal or external rotation and no extension. The diagnosis was severe right hip osteoarthritis. He walked with a markedly antalgic gait and could not put weight on the right side. Authorization was recommended for right total hip arthroplasty. He was temporarily totally disabled. Authorization was requested for total right hip arthroplasty, inpatient hospital stay for 2 days, and outpatient durable medical equipment including front wheeled walker and 3 and 1 commode. The 4/17/15 utilization review non-certified the right total hip arthroplasty and associated surgical requests based on a lack of sufficient course of conservative treatment, including physical therapy or exercises for the right hip.

IMR ISSUES, DECISIONS AND RATIONALES

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

Total Right Hip Arthroplasty: Overturned

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 & Pelvis Chapter, Arthroplasty, Indications for Surgery Hip Arthroplasty.

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: Arthroplasty.

Decision rationale: The California Medical Treatment Utilization Schedule does not provide recommendations for hip surgery. The Official Disability Guidelines recommend total hip arthroplasty when all reasonable conservative measures have been exhausted and other reasonable surgical options have been seriously considered or implemented. Criteria include exercise therapy (supervised physical therapy and/or home rehab exercises) and medications (unless contraindicated non-steroidal anti-inflammatory drugs or steroid injection). Subjective findings should include limited range of motion, or night-time joint pain, or no pain relief with conservative care. Objective findings should include over 50 years of age and body mass index less than 35. Imaging findings of osteoarthritis on standing x-rays or arthroscopy are required. Guideline criteria have been met. This injured worker has worsening right hip and anteromedial thigh pain and weakness. Significant functional difficulty was noted in ambulation. He was not able to return to work. Clinical exam findings were consistent with radiographic evidence of severe osteoarthritis. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including activity modification and medications, and failure has been submitted. Therefore, this request is medically necessary.

Outpatient Durable Medical Equipment Consisting Front Wheeled Walker: Overturned

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 & Leg chapter, Durable Medical Equipment (DME).

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: Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: The California MTUS guidelines do not provide specific guidelines for post-op ambulatory assistant devices. The Official Disability Guidelines state that disability, pain, and age-related impairments determine the need for a walking aid. Assistive devices can reduce pain and allow for functional mobility. The use of a front wheel walker seems reasonable to allow for early post-op functional mobility. The treating physician has documented insufficiency of a cane for functional mobility. Therefore, this request is medically necessary.

3 and 1 Commode: Overturned

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 Knee and Leg, Durable medical equipment (DME).

Decision rationale: The California MTUS is silent regarding this durable medical equipment. The Official Disability Guidelines state that certain DME toilet items (commodes) are medically necessary if the patient is room-confined or when prescribed as part of a medical treatment plan for injury or conditions that result in physical limitations. The use of a 3-in-1 commode following a total hip arthroplasty is reasonable for expected physical limitations and to allow for early functional independence. Therefore, this request is medically necessary.

Inpatient Hospital Stay times (2) days at St. Bernadine's Medical Center: Overturned

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 & Pelvis Chapter, Hospital Length of Stay (LOS).

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 (LOS).

Decision rationale: The California MTUS does not provide recommendations for hospital length of stay. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median and best practice target for a total hip arthroplasty is 3 days. Guideline criteria have been met for inpatient length of stay up to 3 days. Therefore, this request is medically necessary.