
Notice of Independent Medical Review Determination

Dated: **12/11/2013**

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/5/2013
Date of Injury: 7/7/2009
IMR Application Received: 8/8/2013
MAXIMUS Case Number: CM13-0007263

- 1) MAXIMUS Federal Services, Inc. has determined the request for **4 days of in-patient stay is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 pre-op medical clearance for x-ray, EKG and labs is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **7 day rental of a contrast compression unit/continuous flow cryotherapy is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **6 home health physical therapy sessions is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/8/2013 disputing the Utilization Review Denial dated 7/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/12/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **4 days of in-patient stay** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 pre-op medical clearance for x-ray, EKG and labs** is **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **7 day rental of a contrast compression unit/continuous flow cryotherapy** is **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **6 home health physical therapy sessions** is **medically necessary and appropriate**.

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgeon, and is licensed to practice in California. 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

The patient is a 57-year-old male who reported an injury on 10/14/2008. The patient has a history of a prior bariatric surgery and hospital admission for pneumonia. The patient also has a past medical history significant for hypertension, congestive heart failure, cardiorespiratory arrest and depression, among other diagnoses. The patient was noted to have bilateral hip tenderness with limited range of motion and a positive Faber's sign. The patient was noted to have been previously treated with medications, a weight loss program, activity modification, ambulatory devices and diagnostic workup. The patient is noted to have imaging evidence of severe degenerative joint disease of the right hip. The patient has been recommended and authorized for a total hip arthroplasty with an assistant surgeon, 3-day inpatient hospital stay, front-wheeled walker, raised toilet seat and 12 sessions of postoperative physical therapy. The current plan is for a 4-day inpatient stay, pre-operative clearance with x-ray and EKG as well as a 7-day rental of a cryotherapy unit and 6 home physical therapy sessions.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Treatment Utilization Schedule (MTUS)
- Medical Records from:
 - Claims Administrator
 - Employee/Employee Representative
 - Provider

1) Regarding the request for 4 days of in-patient stay.:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines, Hip and Pelvis (acute and chronic), which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on Official Disability Guidelines (ODG), Hip and Pelvic Chapter, which is not part of the MTUS.

Rationale for the Decision:

The request for a 4-day inpatient hospital stay is non-certified. The employee has been authorized for a total hip arthroplasty. The California MTUS and ACOEM Guidelines do not address the length of stay. However, the Official Disability Guidelines state that a 3-day inpatient admission is the best practice target for patients undergoing a total hip replacement. There is a lack of submitted documentation to support the need for a 4-day inpatient stay versus the recommended 3 days. **The request for 4 days of in-patient stay is not medically necessary and appropriate.**

2) Regarding the request for 1 pre-op medical clearance for x-ray, EKG and labs.:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on Official Disability Guidelines (ODG), Low Back Chapter, which is not part of the MTUS.

Rationale for the Decision:

The request for 1 pre-operative medical clearance for x-ray, EKG and labs is medically necessary. The California MTUS and ACOEM Guidelines do not address this request. However, the Official Disability Guidelines do recommend EKGs for patients undergoing high risk surgery and those with additional risk factors. Guidelines recommend pre-operative labs for those patients at an increased risk. Guidelines also state that pre-operative testing, including chest radiography, ECG and laboratory testing, is often performed before surgical procedures. The employee has been authorized for a total hip arthroplasty. The employee has a significant past medical history to include hospital admission for pneumonia, bariatric surgery, congestive heart failure and hypertension as well as radiographic evidence of an enlarged heart. Again, the employee's significant comorbidities and medical clearance to include x-ray, EKG and labs would be medically necessary and standard of care. **The request for 1 pre-op medical clearance for x-ray, EKG and labs is medically necessary and appropriate.**

3) Regarding the request for 7 day rental of a contrast compression unit/continuous flow cryotherapy:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on Official Disability Guidelines (ODG), Hip and Pelvis directed to Knee and Leg Chapter, which is not part of the MTUS.

Rationale for the Decision:

The request for a 7-day rental of a contrast compression unit/continuous flow cryotherapy unit is medically necessary. The California MTUS and ACOEM Guidelines do not specifically address this request. The Official Disability Guidelines Hip and Pelvis Chapter does not address this request; however, other chapters, such as the Knee and Leg as well as the shoulder, recommend a 7-day rental of a continuous flow cryotherapy unit after surgery to decrease pain, inflammation, swelling and narcotic usage. The employee has been authorized for a total hip arthroplasty procedure. Therefore, a 7-day postoperative rental of a continuous flow cryotherapy unit would be medically necessary to decrease pain, inflammation, swelling and narcotic use. **The request for 7 day rental of a contrast compression unit/continuous flow cryotherapy is medically necessary and appropriate.**

4) Regarding the request for 6 home health physical therapy sessions.:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Home health services, page 51, as well as the Post-Surgical Treatment Guidelines, which are part of the MTUS.

Rationale for the Decision:

The California MTUS Guidelines recommend home care for patients who are homebound. Guidelines also recommend up to 24 total sessions of therapy status post hip arthroplasty surgery. The employee has been previously authorized for a total hip arthroplasty surgery and 12 postoperative physical therapy sessions. However, given the employee's comorbidities, including obesity and cardiac disease, an initial 6 home health physical therapy sessions would be medically necessary. The employee would be considered homebound status post hip arthroplasty surgery, and 6 sessions of home physical therapy would be standard of care prior to initiating outpatient physical therapy. **The request for 6 home health physical therapy sessions is medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/skf

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.