

**Notice of Independent Medical Review Determination.
Case Number CM13-000065**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

MAXIMUS Federal Services, Inc. has determined the 4 skilled nurse visits requested **are medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on March 18, 2013 disputing the Utilization Review Denial dated March 1, 2013. A Notice of Assignment and Request for Information was provided to the above parties on April 9, 2013. A decision has been made for each of the treatment and/or services that were in dispute:

MAXIMUS Federal Services, Inc. has determined the 4 skilled nurse visits requested are not medically necessary.

Medical Qualifications of the Professional 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 Physical Medicine and Rehabilitation, has a subspecialty certificate in Pain Management, 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 professional 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated March 1, 2013.

"[Employee] is a 75 year old female Manufacturing Technician with a mechanical fall resulting in immediate left sided hip pain and inability to bear weight. The date of injury is 01/24/13. Broken hip, unspecified has been accepted by the carrier. She is not working secondary to the surgery.

"Co-morbid conditions: Hypothyroid; Hyperlipidemia; HTN; Post-menopausal.
Medications: Synthroid 75 mcg qd; Lipitor 20 mg qd; HCTZ 12.5 mg qd; Perindopril 8 mg qd. s/p Lumbar surgery X2; s/p Left knee surgery.

"1/25/12 ORIF left hip

The employee was transferred from the acute hospital on 02/04/13, 8 days after the left hip ORIF to a skilled nursing facility. She remained in the skilled nursing facility until 02/23/13 when she was discharged to her daughter's home with a request for Physical Therapy and RN visits.

"02/22/13 Discharge orders: May DC on Saturday, resume all pre hosp needs at home. F/U office in 10 days and FeSo4 bid po. RN/PT.

"02/25/13 A request for additional information was faxed to the physician. As only the above d/c orders for 2/22 had been provided. The following was requested: history/physical (acute hospital) operative report and discharge summary (acute hospital) and dc summary for rehabilitation /skilled nursing facility. The frequency and duration for the skilled nurse visits was requested. The frequency for the physical therapy was also requested. Also requested was the number of physical therapy visits the employee received in rehabilitation/physical therapy. Also to confirm if the request was for home PT or for PT to be provided in an outemployee setting.

"03/01/13 Called the office of [REDACTED] regarding the home care requests. He stated that she had a very serious hip fracture and she lost 4 units of blood she required pinning and rodding. He did not discharge her but would recommend home RN 2 times a week for 2 weeks and physical therapy 3 times a week for 8 weeks. He suggests I speak with the surgeon, [REDACTED]. He provided the phone [REDACTED] I CALLED [REDACTED] and spoke with [REDACTED]. She has no order for the employee for home care. The SNF brought the employee in on 02/12/13.

"3/1/13 UR RN called and spoke with [REDACTED] and received clarification regarding the treatment requests. The employee is 75 years old and has a nasty hip fracture. She had a post op wound infection and was in a SNF for 19 days. The Home Health nursing is for wound monitoring."

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 for Independent Medical Review
- Utilization Review by [REDACTED] (dated 03/01/2013)
- Notice of Authorization by [REDACTED] (dated 03/04/2013)
- Employee's Medical Records by [REDACTED] (dated 12/5/2012 through 03/26/2013)
- Mini Mental State Exam by [REDACTED] (dated 12/6/2012)
- Orthopedic Consultation by [REDACTED] (dated 01/25/2013)
- Therapy Report by [REDACTED] PT (dated 01/30/2013)
- Employee's Medical Records by [REDACTED] (dated 01/31/2013 through 03/05/2013)
- Employee's Prescription Information by Skilled Nursing Pharmacy (dated 02/17/2013)
- Employee's Medical Records by [REDACTED] (dated 12/1/2012)
- Employee's Medical Records by [REDACTED] (dated 12/6/2012)
- Employee's Medical Records by [REDACTED] (dated 03/02/2013)
- Employee's Physical Therapy Report by [REDACTED] (dated 03/27/2013)
- Employee's Surgical Post Operative Note by [REDACTED] (dated 01/25/2013)

- Employee's Diagnostic Imaging Report by [REDACTED] (dated 02/11/13)
- Employee's Miscellaneous Medical Records
- Chronic Pain Medical Treatment Guidelines, P. 51
- ODG Physical Medicine Guidelines – Hip & Pelvis

Regarding the request for 4 skilled nurse visits:

Medical Treatment Guideline(s) Relied Upon by the Professional Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (2009), Chronic Pain Medical Treatment Guidelines (2009), and Post-Surgical Treatment Guidelines (2009). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee is a 75 year old female. Her past medical history is relevant for X-stop, lumbalgia, and knee surgery. The employee required 3 units of transfusion during and following surgery. These factors affect her rehabilitation potential, and in general older employees with more co-morbidities may need longer or more aggressive post-surgical care and rehabilitation. This appears to be the case in this employee, as she had an admission to a skilled nurse facility (SNF) with post-operative physical therapy done there. Her progress in terms of functional goals and number of visits at the SNF were not clearly specified in the submitted documentation. There is a note dated 2/1/13, which specified functional goals of: (1) contact guard assist for gait 100 feet, bed mobility, and transfers; and (2) stand by assist for gait with rolling walker 200 feet and bed mobility in the long term.

The injured worker sustained a left hip intertrochanteric fracture and is status post open reduction internal fixation (ORIF).

In the case of this employee, she was transferred to a SNF following her ORIF of the hip. The total number of physical therapy session performed while at the SNF is unknown. Also, there is no documentation of what functional goals were met at the time of SNF discharge. The utilization reviewer made the determination of certifying 9 visits of physical therapy given her co-morbidities and the nature of her fracture and repair. Often, injured workers will also require outpatient rehabilitation when discharged from a SNF where rehabilitation was performed. The 4 skilled nurse visits requested are 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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

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

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