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**Notice of Independent Medical Review Determination**

Dated: 10/8/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/16/2013  
Date of Injury: 11/15/2012  
IMR Application Received: 7/17/2013  
MAXIMUS Case Number: CM13-0001868

- 1) MAXIMUS Federal Services, Inc. has determined the request for internal medicine consult **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for sleep study **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for physical therapy for the left shoulder and left hip, three (3) times a week for four (4) weeks **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/17/2013 disputing the Utilization Review Denial dated 7/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/19/2013. 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 internal medicine consult **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for sleep study **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for physical therapy for the left shoulder and left hip, three (3) times a week for four (4) weeks **is not 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 Physical Medicine and Rehabilitation, has a subspecialty 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 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.

### **Case Summary:**

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 16, 2013

██████████ is a 69 year-old female sustained an injury on 11/15/12. It was reported that her place of employment was doing renovations and she had to step over an awkwardly placed pallet in order to retrieve merchandise. When she walked over the pallet she tripped as her left foot hit it and she fell to the floor. She fell onto her left shoulder, elbow, and left hip. She underwent left hip surgery that day of the injury and was given a splint for her left elbow. The claimant started attending PT but she developed experiencing headaches, dizziness, lethargy and imbalance while standing. She sustained a fall at the PT office. On 5/14/13 upon exam her left shoulder ROM when left forward flexion was 126 degrees and abduction 126 degrees and was positive for impingement sign. The left elbow ROM during flexion was 126 degrees, extension 162 degrees, supination 77 degree, and pronation 68 degrees. She is on total disability for 6 weeks.”

### **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 (received 7/17/13)
- Utilization Review Determination from [REDACTED] (dated 7/16/13)
- Medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for internal medicine consult :**

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

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), pg. 127 which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

##### Rationale for the Decision:

The employee sustained a work-related injury on November 15, 2012 resulting in left elbow, shoulder and hip injury. The medical records provided for review indicate initial diagnoses of sprained left arm and left hip fracture; she had surgery on 11/15/2012 with a pre-operative diagnosis of left minimally displaced foraminal neck fracture, left radial neck fracture, and left greater tuberosity fracture and procedure performed was a closed reduction and pinning of left hip with screws. There was post-operative physical therapy. The request is for an internal medicine consult.

The MTUS ACOEM guidelines state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. The medical records reviewed do not indicate significant internal medicine issues. The medical report of 5/1/13 indicates that the orthopedist believed the employee had reached maximum medical improvement with a normal affect and normal gait; full range of motion of the left elbow and forearm with mild pain and had full range of motion of the left hip and thigh and was thought to be stable. No clinical note was submitted to indicate a medical necessity for an internal medicine consult. Therefore, the request for internal medicine consult is not medically necessary and appropriate.

#### **2) Regarding the request for sleep study:**

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

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (Pain Chapter) Polysomnography which is a medical treatment guideline that is not part of the Medical Treatment Utilization Schedule (MTUS). The

provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer stated that MTUS did not address the issue at dispute, and found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on November 15, 2012 resulting in left elbow, shoulder and hip injury. The medical records provided for review indicate initial diagnoses of sprained left arm and left hip fracture; she had surgery on 11/15/2012 with a pre-operative diagnosis of left minimally displaced foraminal neck fracture, left radial neck fracture, and left greater tuberosity fracture and procedure performed was a closed reduction and pinning of left hip with screws. There was post-operative physical therapy. The request is for sleep study.

Official Disability Guidelines (ODG) state that a sleep study is recommended after at least six months of an insomnia complaint. The medical records provided for review do not indicate that the employee has any significant sleep issues such as insomnia or snoring which would meet guideline criteria for sleep study. The request for sleep study is not medically necessary and appropriate.

- 3) Regarding the request for physical therapy for the left shoulder and left hip, three (3) times a week for four (4) weeks :**

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

The Claims Administrator based its decision on the MTUS Chronic Pain Medical Treatment Guidelines (2009) pg. 98-99 which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on November 15, 2012 resulting in left elbow, shoulder and hip injury. The medical records provided for review indicate initial diagnoses of sprained left arm and left hip fracture; she had surgery on 11/15/2012 with a pre-operative diagnosis of left minimally displaced foraminal neck fracture, left radial neck fracture, and left greater tuberosity fracture and procedure performed was a closed reduction and pinning of left hip with screws. There was post-operative physical therapy. The request is for physical therapy for the left shoulder and hip, three (3) times a week for four (4) weeks.

MTUS Chronic Pain Medical Treatment Guidelines state that a certain amount of conservative care should be given and then a home exercise program should be provided. According to the medical report of 5/1/13, the employee has reached maximum medical improvement with full range of motion of the left elbow and forearm, normal contour of the left shoulder and arm, and no sign of acute fracture or trauma to the left hip and thigh, and full range of motion and stability is

noted to the left hip and thigh. The medical records reviewed indicate the employee has undergone and completed physical therapy, but continues to report pain. There is no documentation of functional deficits which would meet guideline criteria for additional physical therapy. The request for physical therapy for the left shoulder and hip, three (3) times a week for four (4) weeks is not 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, 18<sup>th</sup> Floor  
Oakland, CA 94612

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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.