

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 12/16/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	5/21/2013
Date of Injury:	2/21/2013
IMR Application Received:	6/7/2013
MAXIMUS Case Number:	CM13-0000600

- 1) MAXIMUS Federal Services, Inc. has determined the request for **post-op cold therapy unit is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **post-op TENS unit is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **post-op physical therapy for the left knee is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/7/2013 disputing the Utilization Review Denial dated 5/21/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/8/2013. 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 **post-op cold therapy unit** is **not medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **post-op TENS unit** is **not medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **post-op physical therapy for the left knee** 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.

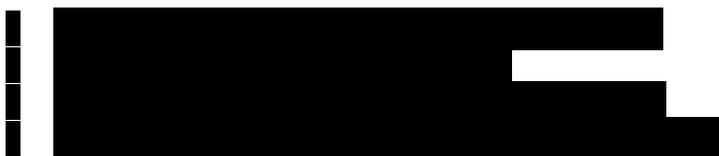
### **Expert Reviewer Case Summary:**

This is a male patient with a date of injury of February 21, 2013. A utilization review determination dated May 21, 2013 recommends modified certification for cryotherapy unit for seven days postoperatively, tens unit for 30 days postoperatively, and physical therapy for six visits. The initial therapy request was for 2 visits a week for 4 weeks. The utilization review determination recommends a certification for arthroscopy with partial medial meniscectomy and debridement. Review of records identifies that when the patient was seen on April 26, 2013, the patient was complaining of pain in the medial aspect of the left knee and is having complaints of popping and clicking in the left knee with motion. He was experiencing buckling and giving away of the knee. Physical examination of the left knee indicate there is slight intra-articular effusion. There is no soft tissue swelling or misalignment. Pain is elicited on palpation over the medial joint line. The patella appears well situated within the trochlear notch. Patellar apprehension sign is negative. Patella appears to track smoothly within the trochlea and the patella grind test is positive. There is patellar crepitation noted. Quadriceps angle is less than 10°, and range of motion of the left knee is from 0 to 150°, Verus and Valgus stress at full extension and 30° of flexion are normal. Pivot shift, anterior and posterior drawer, and external rotation recruitment are all negative. There is positive McMurray's test and positive Appleys compression test. Review of medical records indicate that he was provided a knee brace, was sent to physical therapy, and placed on anti-inflammatories. MRI scan of the left knee dated April 9, 2013 demonstrates an oblique tear of the posterior horn of the medial meniscus. Also noted is chondromalacia grade 3 and 4 of the

far anterior medial femoral condyle of the patellofemoral compartment. There is noted to be a 5 mm cartilaginous intra-articular loose body present posteriorly. A Request for Authorization for Medical Treatment form dated 5/16/2013 requests "outpatient surgery of left, arthroscopy with partial medial meniscectomy and debridement. Cold unit for 14 days. IF unit for 30 days. Post-op physical therapy 2x4 to begin 10-12 days post surgery." An application for Independent Medical Review dated 6/4/2013 requests "PO cold therapy unit, PO TENS, PO physical therapy for the left knee."

**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:



**1) Regarding the request for post-op cold therapy unit :**

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, Knee & Leg Chapter, which is not a part of 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 the Official Disability Guidelines (ODG) Knee Chapter, which is not a part of MTUS.

Rationale for the Decision:

The Official Disability Guidelines indicate that continuous cold therapy is recommended as an option after surgery for seven days including home use. The medical records available for review clearly indicates that surgery has been certified. The initial request for cold therapy was for 14 days, clearly beyond what is recommended by guidelines. **The request for postoperative (PO) continuous cryotherapy for seven days is not medically necessary and appropriate.**

**2) Regarding the request for post-op TENS unit :**

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 CA Medical Treatment Utilization Schedule (MTUS), TENS, page 114-117, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, TENS and Interferential Current Stimulation (ICS), page 114-120, which is a part of MTUS.

Rationale for the Decision:

The MTUS Guidelines indicate that post operative TENS therapy is covered for 30 days or less. Within the documentation available for review, the current request is for postoperative TENS unit with no duration specified. The initial request was for an interferential unit (IF). There is no documentation that the employee has significant pain during the postoperative period that is limiting their ability to perform an exercise program, as recommended by guidelines as criteria for an interferential unit. Additionally, guidelines clearly do not support the open-ended use of either TENS or IF therapy. **The request for postoperative (PO) TENS unit is not medically necessary and appropriate.**

**3) Regarding the request for post-op physical therapy for the left knee :**

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 Medical Treatment Utilization Schedule (MTUS) PostSurgical Guidelines, and ACOEM Occupational Medicine Practice Guidelines, 2<sup>nd</sup> Ed., Chapter 13, which is a part of MTUS.

The Expert Reviewer based his/her decision on the Postsurgical Treatment Guidelines, Postsurgical treatment guidelines, pages 10-11 and Knee, pages 24-25, which is a part of MTUS.

Rationale for the Decision:

The MTUS Guidelines indicate recommend a maximum of recommend 12 therapy visits over 12 weeks for the post surgical treatment of meniscal injuries. The guidelines recommend an initial trial of 6 visits. More visits may be considered provided there is documentation of objective functional improvement with the initial visits. Within the documentation available for review, it is clear that surgery has been certified. The current request for postoperative therapy contains no frequency or duration. Guidelines do not support the application of physical therapy on an open-ended basis. The initial therapy request was for 8 visits, more than the initial 6 visits recommended by guidelines. **The request for postoperative (PO) physical therapy for the left knee 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,

Paul Manchester, MD, MPH  
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.