MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270

MAXIMUS Federal Services

Independent Medical Review Final Determination Letter

[redacted]

Dated: 12/18/2013

Employee:	[redacted]
Claim Number:	[redacted]
Date of UR Decision:	7/15/2013
Date of Injury:	10/30/2002
IMR Application Received:	8/15/2013
MAXIMUS Case Number:	CM13-0011567

DEAR [redacted]

MAXIMUS Federal Services has completed the Independent Medical Review ("IMR") of the above workers' compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers' Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [redacted]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in Michigan, Nebraska, and Texas 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 physician 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/services.

DOCUMENTS REVIEWED

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 Records from the Claims Administrator, Employee/Employee Representative, and Provider
- Medical Treatment Utilization Schedule (MTUS)

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This claimant is a 40-year-old female with a date of injury of 10/30/2003. While working, she noticed a shoplifter was running out of the store and jumped on her and kicked her on her knees, and she felt immediate pain and discomfort, with more pain later on. She was seen and evaluated on 10/25/2010, at which time it was noted that she had undergone ACL reconstruction, apparently to the left knee. An MRI dated of the left knee revealed thickening of the medial patellar retinaculum, focal moderate grade cartilage loss, and moderate-sized popliteal cyst. She was seen for initial physical therapy evaluation on 09/28/2012. On 02/18/2013, an MRI of the right knee was obtained, which revealed a trace joint effusion and a small popliteal cyst at the posteromedial aspect of the knee. There was minimal chondromalacia of the patellar and there was no evidence of meniscal tear or ligament injury. This claimant returned on 06/17/2013 to clinic with further evaluation and had full range of motion on both knees. She described the right knee bothering her and wanted to get something done for that knee. Diagnoses include status post left knee patellofemoral ligament reconstruction and right knee previous surgery with continued instability. The plan at that time was to proceed with a right knee diagnostic arthroscopy with debridement of the meniscus or anterior cruciate ligament as indicated with open repair of the medial patellofemoral ligament. Postoperative physical therapy, postoperative cold therapy unit, and postoperative knee brace, as well as a pain pump were also recommended.

IMR DECISION(S) AND RATIONALE(S)

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

1. The right knee diagnostic arthroscopy and surgery, tissue repair and debridement meniscus or anterior cruciate ligament as indicated and able; open repair medial patellar femoral ligament is not medically necessary and appropriate.

The Claims Administrator based its decision on the California MTUS, 2009, Knee complaints, ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 13, pgs. 343-345, CA MTUS, Postsurgical Treatment Guidelines, and Official Disability Guidelines (ODG), Knee and Leg Chapter, and Postsurgical Treatment Guidelines, Textbook of Orthopedics, MPFL reconstruction.

The Physician Reviewer based his/her decision on the Knee Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 13) and knee surgery, pgs. 343-345.

The Physician Reviewer's decision rationale:
This request is for right knee diagnostic arthroscopy and surgery, tissue repair and debridement of the meniscus or anterior cruciate ligament as indicated with open repair of the medial patellofemoral ligament. The records indicate that MRI dated 02/18/2013 of the right knee reveals a trace joint effusion and minimal chondromalacia of the patella, but there is no evidence of meniscal tear or ligaments injury. The extensor mechanism was intact as well. The last clinical visit of 08/26/2013 noted the employee had full range of motion to the right knee, going from 135 degrees of flexion to approximately 180 degrees of extension. Although it was noted that the employee had medial patellofemoral ligament instability on the right knee, there was no examination on that date to demonstrate instability. California MTUS/ACOEM Knee Chapter indicates surgical consideration can be given for patients who have activity limitation for more than 1 month, failure of exercise programs to increase range of motion and strength. There should also be documentation for an ACL tear and repair and/or reconstruction. There should be significant symptoms of instability caused by ACL incompetence. There should be clear signs of meniscus injury according to California MTUS/ACOEM on imaging studies to warrant this level of surgical procedure for a meniscus. The submitted records do not indicate the employee has meniscal tear of an anterior cruciate ligament tear or ligament instability at this time. The physical exam only demonstrates that the employee has flexion and extension that is considered normal to the right knee. The records also fail to indicate that the employee has had significant current conservative care to address strength and/or range of motion deficits. The current records do not describe a condition for which this procedure would be considered medically necessary. **The request for right knee diagnostic arthroscopy and surgery, tissue repair and debridement meniscus or anterior cruciate ligament as indicated and able; open repair medial patellar femoral ligament is not medically necessary and appropriate.**

2. The post-operative cold therapy unit rental for the right knee is not medically necessary and appropriate.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

3. The post-operative knee brace for the right knee is not medically necessary and appropriate.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

4. The pain pump is not medically necessary and appropriate.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

5 Post-physical therapy for the right knee two (2) times four (4) is not medically necessary and appropriate.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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.

[redacted]

CM13-0011567