

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: **11/21/2013**

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/31/2013  
Date of Injury: 4/28/2008  
IMR Application Received: 8/13/2013  
MAXIMUS Case Number: CM13-0012318

- 1) MAXIMUS Federal Services, Inc. has determined the request for **left knee arthroscopic surgery** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **cold machine for the left knee post op** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **crutches post op for the left knee** is not **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **post op physical therapy 3 times a week x 4 weeks for the left knee** is not **medically necessary and appropriate**.
- 5) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy 3 times a week x 4 weeks for the right knee and bilateral shoulders** is not **medically necessary and appropriate**.

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/13/2013 disputing the Utilization Review Denial dated 7/31/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/18/2013. 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 **left knee arthroscopic surgery** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **cold machine for the left knee post op** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **crutches post op for the left knee** is not **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **post op physical therapy 3 times a week x 4 weeks for the left knee** is not **medically necessary and appropriate**.
- 5) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy 3 times a week x 4 weeks for the right knee and bilateral shoulders** 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 Orthopedic Surgery, 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 61 year old female claimant who sustained an injury on 4/28/2008 when she slipped and fell. The claimant's diagnosis was documented as disc protrusion cervical spine; impingement right shoulder, partial rotator cuff tear with impingement left shoulder, disc protrusion lumbar spine, meniscal tear right knee status post arthroscopy, meniscal tear left knee. The claimant was status post 6/4/2013 right knee arthroscopic partial medial meniscectomy, left knee arthroscopic partial lateral meniscectomy, right knee arthroscopic removal of loose body.

A 2/28/2013 MRI of the left shoulder report findings revealed acromioclavicular joint hypertrophy, degeneration and small effusion in acromioclavicular joint; glenohumeral joint is notable for small subchondral cyst laterally but normal alignment; type 1 acromion without downsloping or lateral slope; supraspinatus tendon demonstrated mild thickening and increased signal intensity consistent with tendinosis; possible small supraspinatus tendon partial thickness under surface tear but no full thickness tear;

impression report was supraspinatus tendinosis with possible partial thickness under surface tear but no full thickness tear; acromioclavicular joint hypertrophy and degeneration with small acromioclavicular joint effusion; labrum not well visualized but no large tear; no fracture or subluxation.

A 3/18/2013 CT of the upper extremity with contrast report findings revealed post surgical changes in right shoulder with 4 metallic anchors in right humeral head; no fracture or subluxation; contrast in shoulder joint; tear in the supraspinatus tendon anteriorly and in adjacent rotator interval with contrast extending into subacromial/subdeltoid bursa and the acromioclavicular joint; type 1 acromion and degenerative change in acromioclavicular joint; subacromial space narrowed; labrum intact; mild thinning of articular cartilage over humeral head; report impression was rotator cuff tear in supraspinatus tendon and rotator interval with contrast extending into subacromial/subdeltoid bursa and acromioclavicular joint; degenerative arthritis in acromioclavicular joint; narrowing of subacromial space

On 7/16/2013 the claimant had a urine toxicology screen and the result was documented as being inconsistent with reported medication list. The reported medication list was Dilaudid, Norco and Flexeril.

The 8/12/2013 Dr. [REDACTED] office visit note stated that the claimant reported pain in her neck, right and left shoulders, lower back, right and left knee. The claimant was using cane because of knee pain which has resulted in problems with her trigger finger of right 4<sup>th</sup> finger and carpal tunnel syndrome of right hand. Her right shoulder exam revealed flexion 160; abduction 160; internal rotation 60; external rotation 60; pain with motion; tenderness at rotator cuff; positive Neer sign and Hawkins test. Her left shoulder exam revealed flexion 160; abduction 160; internal rotation 60; external rotation 60; pain with motion; tenderness at rotator cuff; positive Neer sign and Hawkins test. Her right knee exam revealed extension 0; flexion 130; crepitus, pain and moderate effusion noted; tenderness present at medial, lateral, and patellofemoral joint. Her left knee exam revealed extension 0; flexion 120; moderate effusion noted; tenderness present at medial and lateral joint line; McMurray test elicits pain in medial compartment. The plan was surgical intervention of the left knee with cold machine, physical therapy; treatment of trigger finger and right carpal tunnel syndrome; medications.

Dr. [REDACTED] is requesting left knee arthroscopic surgery, cold machine for the left knee post op, crutches post op for the left knee, post op physical therapy 3 times a week x 4 weeks for the left knee, and physical therapy 3 times a week x 4 weeks for the right knee and bilateral shoulders.

#### **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 Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for left knee arthroscopic surgery:**

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), Knee Chapter, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Knee Complaints, Chapter 13, pgs. 344-345, which are part of the MTUS, and the Official Disability Guidelines (ODG), Knee Chapter, Indications for Surgery, which is not part of the MTUS.

Rationale for the Decision:

Upon review of the charts, the employee had an injury on April 28, 2008. On June 4, 2013, there is evidence of an arthroscopic procedure and it is unclear based on the operative report provided whether this was simply a right arthroscopic procedure or bilaterally. There is mention in the operative report that the procedure performed included:

1. An arthroscopic partial medial meniscectomy.
2. Arthroscopic partial lateral meniscectomy and it goes on to say "left knee" as well as arthroscopic removal of loose body in the right knee.

Please note as well that based upon the information provided, the last visit with Dr. [REDACTED] of August 12, 2013, goes on to say that the employee's left knee has evidence of McMurray's with pain elicited in the medial compartment as well as a moderate effusion, however, there is lack of any documentation of any conservative measures including, but not limited to, diagnostic cortisone injections and/or physical therapy as well as documentation of objective functional limitations.

As such and based upon the ACOEM Guidelines, as well as the Official Disability Guidelines, with the lack of documentation as noted above, the proposed surgical procedure cannot be deemed medically appropriate. **The request for left knee arthroscopic surgery is not medically necessary and appropriate.**

**2) Regarding the request for cold machine for the left knee post op:**

Since the primary procedure **left knee arthroscopic surgery** is not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

**3) Regarding the request for crutches post op for the left knee:**

Since the primary procedure **left knee arthroscopic surgery** is not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

**4) Regarding the request for post op physical therapy 3 times a week x 4 weeks for the left knee:**

Since the primary procedure **left knee arthroscopic surgery** is not medically necessary and appropriate, none of the associated services are medically necessary and appropriate.

**5) Regarding the request for physical therapy 3 times a week x 4 weeks for the right knee and bilateral shoulders:**

Since the primary procedure **left knee arthroscopic surgery** is not medically necessary and appropriate, none of the associated services 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,

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.