MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 8/20/2013

Employee:	
Claim Number:	
Date of UR Decision:	7/8/2013
Date of Injury:	9/7/2009
IMR Application Received:	7/10/2013
MAXIMUS Case Number:	CM13-0001080

1) MAXIMUS Federal Services, Inc. has determined the request for a rental of continuous passive motion machine (CPM) for six (6) weeks **is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for physical therapy, two (2) times a week for twelve (12) weeks **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for Polar Care ice machine **is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for a pain management consultation **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/10/2013 disputing the Utilization Review Denial dated 7/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/10/2013. 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 a rental of continuous passive motion machine (CPM) for six (6) weeks **is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for physical therapy, two (2) times a week for twelve (12) weeks **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for Polar Care ice machine **is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for a pain management consultation **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.

Case Summary:
Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 8, 2013

"According to the medical records, the patient is a 37-year-oiO male who sustained an industrial injury on 9/7/09. The patient is status post right lateral release and then right knee chondroplasty on 1/8/13, that demonstrated, according to a 3/7/13 consultation with Dr. [redacted] grade 3-4 chondromalacia of the patella.

“An MRI report of right knee, dated 4122/12 (prior to 1/8/13 surgery), described the following impressions: 1. No evidence of meniscus or ligament tear. 2. No evidence of stress reaction or fracture. 3. Focal chondral softening median eminence and lateral patellar facette.

“A previous request for right knee patellar femoral arthroplasty was recommended non-certified in review on 3125/13. It was noted by the reviewer that he was unable to find any peer reviewed articles indicating good long-term results of this procedure in a patient this young. There are other less destructive choices that have not been tried

such as tibial tubercle elevation or cartilage transplantation. It was noted that the doctor Is welcome to provide level 1 evidence to support his long-term predictions for the requested surgery.

"An appeal request for right knee patellofemoral replacement was non-certified by Dr. [redacted] in peer review on 5/6/13, as the submission of the AAOS course article by Dr. [redacted] is not considered level 1 evidence for the requested surgical procedure. It remains that patella-femoral replacement in this young patient is not supported by the evidence-based guidelines, or substantive peer-reviewed literature.

"According to a 6/25/13 examination by Dr. [redacted] the patient Is still having significant pain and swelling in the front of his Knee that is coming up on his quadriceps now with running, jogging, standing, stairs, and getting up from a seated position. Examination reveals midline tracking of the patella, severe patellofemoral crepitus, and pain upon compression. There is no medial and lateral joint line tenderness. He has stable ligamentous examination. There is mild effusion. The patient agrees that he might be a little young for patellofemoral arthroplasty at this point, and he is not ready to take the next step at this point. Dr. [redacted] states that microfracture is the patient's first option for the patellofemoral joint, trochlea, as well as the patella. The patient understands it might not offer significant long-term relief, but it might offer enough short-term relief that he can perform his regular duties. Work status is unspecified."

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 7/10/13)
- Utilization Review Determination (dated 7/8/13)
- Employee medical records from [redacted] MD (dated 3/7/13-6/25/13)
- Employee medical records from [redacted] MD (dated 6/6/12-2/11/13)
- Employee medical records from [redacted] MD (dated 4/6/11-4/25-13)
- Employee medical records from [redacted] dated (4/22/12)
- Knee Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 13)
- Appendix C – Postsurgical Treatment Guidelines Evidence-Based Reviews (May, 2009), pg 48-52
- Official Disability Guidelines (ODG) (latest version), Knee Chapter

1) **Regarding the request for the rental of continuous passive motion machine (CPM) for six (6) weeks:**

   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), Knee Chapter (online version), which 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 found MTUS does not specifically address the issue at dispute. The Expert Reviewer found that the ODG guidelines, which are not part of the MTUS, used by the Claims Administrator were relevant and appropriate for the issue at dispute.

Rationale for the Decision:
The employee sustained a work-related injury to the right knee on 9/7/2009. The medical records provided for review indicate treatment has consisted of a right lateral release and right knee chondroplasty. The medical report of 1/8/13 indicated mild grade I and early grade II chondral wear to the medial compartment of the right knee, diffuse grade I and early grade II chondral wear to the lateral compartment of the right knee, and grade II to III chondral wear to the lateral facet of the patella. The request is for the rental of a continuous passive motion machine (CPM) for six weeks.

The Official Disability Guidelines (ODG) recommends the use of a continuous passive motion machine (CPM) for postoperative care for 4-10 days but not more than 21 days. The rental of a continuous passive motion machine (CPM) for six (6) weeks **is not medically necessary and appropriate.**

2) **Regarding the request for physical therapy, two (2) times a week for twelve (12) weeks:**

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

The Claims Administrator based its decision on the Postsurgical Treatment Guidelines Evidence-Based Reviews (May, 2009), 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 to the right knee on 9/7/2009. The medical records provided for review indicate treatment has consisted of a right lateral release and right knee chondroplasty. The medical report of 1/8/13 indicated mild grade I and early grade II chondral wear to the medial compartment of the right knee, diffuse grade I and early grade II chondral wear to the lateral compartment of the right knee, and grade II to III chondral wear to the lateral facet of the patella. The request is for physical therapy, two (2) times a week for twelve (12) weeks**.**

The Postsurgical guidelines allow for twelve physical therapy sessions following surgery. The request exceeds guideline recommendations. Physical therapy,

two (2) times a week for twelve (12) weeks, **is not medically necessary and appropriate.**

3) **Regarding the request for a Polar Care ice machine:**

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), Knee Chapter (online version), which 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 found MTUS was silent on the issue at dispute and based his/her decision on the Official Disability Guidelines (ODG), Knee Chapter (online version), which is not part of the Medical Treatment Utilization Schedule (MTUS), as relevant and appropriate for the issue at dispute.

Rationale for the Decision:
The employee sustained a work-related injury to the right knee on 9/7/2009. The medical records provided for review indicate treatment has consisted of a right lateral release and right knee chondroplasty. The medical report of 1/8/13 indicated mild grade I and early grade II chondral wear to the medial compartment of the right knee, diffuse grade I and early grade II chondral wear to the lateral compartment of the right knee, and grade II to III chondral wear to the lateral facet of the patella. The request is for a Polar Care ice machine.

4) **Regarding the request for a pain management consultation:**

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), pg. 92, 127, which 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 found that the MTUS did not address the issue at dispute and based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), Chapter 7, pg. 503 (online version), which is not part of the Medical Treatment Utilization Schedule (MTUS), as relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:
The employee sustained a work-related injury to the right knee on 9/7/2009. The medical records provided for review indicate treatment has consisted of a right lateral release and right knee chondroplasty. The medical report of 1/8/13 indicated mild grade I and early grade II chondral wear to the medial compartment of the right knee, diffuse grade I and early grade II chondral wear to the lateral compartment of the right knee, and grade II to III chondral wear to the lateral facet of the patella. The request is for a pain management consultation.

ACOEM guidelines state referral may be made to other specialists in circumstances where a diagnosis is uncertain or extremely complex, there are psychosocial factors present, or the treatment plan may benefit from additional expertise. The medical records reviewed show a diagnosis that is consistent with the physical findings, the diagnosis is not uncertain or extremely complex, and lesser measures have not demonstrated failure to provide pain relief. The pain management consultation **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, 18th 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.