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**Notice of Independent Medical Review Determination**

Dated: 9/17/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/7/2013

6/29/2010

7/16/2013

CM13-0001628

- 1) MAXIMUS Federal Services, Inc. has determined the requested Tramadol ER 200mg #30 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested hinge brace/fitting left knee **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the requested deep water class **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/16/2013 disputing the Utilization Review Denial dated 7/7/2013. 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 requested Tramadol ER 200mg #30 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested hinge brace/fitting left knee **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the requested deep water class **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, 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 9, 2013:

"Employee is a 49 year old male Correctional Sergeant who was injured on DOI 06/29/10 while at work running to an alarm, he stepped off the cement onto uneven ground causing his left knee to twist in pain. The Lower Back Area, and left Knee claims have been accepted by the carrier."

### 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 (dated 7/16/2013)
- Utilization Review from [REDACTED] (dated 7/7/2013)
- Medical records from [REDACTED], MD (dated 8/3/12-6/7/13)
- Chronic Medical Treatments Guidelines (May, 2009) Pt 1 Introduction pgs 93-94 & 113 and pg. 22
- Knee Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 13), pg. 346, Summary of Recommendations

**1) Regarding the request for Tramadol ER 200mg #30:**

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatments Guidelines (May, 2009), pg. 93-94, 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 June 29, 2010 to the left knee, and lower back area. The medical records provided for review indicate the diagnoses of left knee pain, meniscal tear, status post surgery, and knee sprain. Treatments have included diagnostic imaging studies, knee surgery, epidural steroid injections, physical therapy, and medication management. The request is for Tramadol ER 200 mg #30.

The MTUS Chronic Pain guidelines recommend tramadol for individuals with moderate to severe pain. The medical report of 6/7/13 did not document pain levels on a visual analog scale (VAS) scale. The medical records reviewed indicate the last documented VAS scale was on 3/7/13 at which time the pain was reported as 2/10. This would not meet guideline criteria for moderate to severe pain. The request for Tramadol ER 200 mg #30 is not medically necessary and appropriate.

**2) Regarding the request for hinge brace/fitting left knee:**

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

The Claims Administrator based its decision on the Knee Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 13) Table 13-6, pg. 346-347, Summary of Recommendations, 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 June 29, 2010 to the left knee, and lower back area. The medical records provided for review indicate the diagnoses of left knee pain, meniscal tear, status post surgery, and knee sprain. Treatments have included diagnostic imaging studies, knee surgery, epidural steroid injections, physical therapy, and medication management. The request is for hinge brace/fitting left knee.

The MTUS ACOEM guidelines indicate there is limited research-based evidence to support short periods of immobilization after an acute injury to relieve symptoms. The guidelines also state that there is not enough inclusion criteria for research-based evidence to support functional bracing as part of a rehabilitation program or prophylactic bracing or prolonged bracing for anterior cruciate ligament (ACL) deficient knee. The medical records provided for review do not document evidence of instability to the left knee. The request for hinge brace/fitting left knee is not medically necessary and appropriate.

**3) Regarding the request for deep water class:**

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

The Claims Administrator based its decision on the Chronic Medical Treatments Guidelines (May, 2009), pg. 22, 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 June 29, 2010 to the left knee, and lower back area. The medical records provided for review indicate the diagnoses of left knee pain, meniscal tear, status post surgery, and knee sprain. Treatments have included diagnostic imaging studies, knee surgery, epidural steroid injections, physical therapy, and medication management. The request is for deep water class.

The MTUS Chronic Pain guidelines state that aquatic therapy is an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. The medical records submitted for review do not indicate that the employee is unable to participate in land-based physical therapy. There is also a lack of documentation of any functional deficits that would support the need for aquatic therapy. The request for deep water class 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

/hs

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.