
Notice of Independent Medical Review Determination

Dated: 10/14/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/8/2013

4/7/2006

7/16/2013

CM13-0001663

- 1) MAXIMUS Federal Services, Inc. has determined the request for right knee arthroscopy, chondroplasty, partial medial menisectomy **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for purchase of a Polar Care cold therapy unit **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for physical therapy 12 sessions **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for post-op medications (no name, dosage or quantity specified) **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 7/8/2013. 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 request for right knee arthroscopy, chondroplasty, partial medial meniscectomy **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for purchase of a Polar Care cold therapy unit **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for physical therapy 12 sessions **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for post-op medications (no name, dosage or quantity specified) **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:

"BRIEF CLINICAL SUMMARY:

No information other than that the patient injured his right knee on 7 April 2006. No record of patient complaints or physical findings. There was a report of an MRI of the right knee showing a tear of the medical meniscus."

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 7/16/2013)
- Utilization Review Determination from [REDACTED] (dated 7/8/2013)
- Medical Records provided by the claims administrator
- Medical Treatment Utilization Schedule

1) Regarding the request for right knee arthroscopy, chondroplasty, partial medial meniscectomy:

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, 2nd Edition), Chapter 13 (2008 Revision), pg. 1020-1021, not a 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 Knee Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition), Chapter 13, pg. 343-345, part of MTUS, and the Official Disability Guidelines (ODG), Knee & Leg Chapter, Meniscectomy, a medical treatment guideline, not part of the MTUS, was applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related injury on 4/7/06 to the right knee. The medical records submitted and reviewed indicate diagnoses include osteoarthritis of the knee and chronic knee pain. The records indicate treatments have included previous right knee surgery. The request is for right knee arthroscopy, chondroplasty, and partial medial meniscectomy.

MTUS ACOEM guidelines state that arthroscopic partial meniscectomy usually has a high success rate for cases where there is clear evidence of a meniscus tear. However, the meniscal tear on the MRI is likely to represent a scar from the previous meniscectomy surgery. The Official Disability Guidelines indicate the criteria for meniscectomy includes conservative care and two subjective and objective clinical findings. The medical records reviewed indicate the employee has generalized knee osteoarthritis and there is indication of cartilage damage. Revision arthroscopic surgery would not be recommended due to unlikely significant improvement based on the continued degenerative changes. Therefore, the request for right knee arthroscopy, chondroplasty, and partial medial meniscectomy **is not medically necessary and appropriate.**

2) Regarding the request for Error! Reference source not found.:

Since the right knee arthroscopy, chondroplasty, and partial medial meniscectomy is not medically necessary, none of the associated services are medically necessary and appropriate.

3) Regarding the request for physical therapy 12 sessions:

Since the right knee arthroscopy, chondroplasty, and partial medial meniscectomy is not medically necessary, none of the associated services are medically necessary and appropriate.

4) Regarding the request for post-op medications (no name, dosage or quantity specified):

Since the right knee arthroscopy, chondroplasty, and partial medial meniscectomy is not medically necessary, 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;

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

/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.