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**Notice of Independent Medical Review Determination**

Dated: 9/6/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/2/2013  
Date of Injury: 11/12/2007  
IMR Application Received: 7/16/2013  
MAXIMUS Case Number: CM13-0001738

- 1) MAXIMUS Federal Services, Inc. has determined the request for an off-the-shelf upright brace with padding, liner, and a suspension wrap with a non-corrosive finish **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 3 months of Bionicare knee device supplies **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 3 months of Bionicare night wrap system supplies **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 7/2/2013. 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 an off-the-shelf single upright brace with padding, liner, and a suspension wrap with a non-corrosive finish **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 3 months of Bionicare knee device supplies **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 3 months of Bionicare night wrap system supplies **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, has a subspecialty in Sports Medicine 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 2, 2013.

The patient is a 46 year old male with a date of injury of 11/12/2007. Under review are prospective requests for 1 Off the shelf single upright brace with pad, liner, suspension wrap non-corrosive finish, 3 months of Bionicare Knee Device supplies, and 3 months supply of Bionicare Night Wrap system.

Review of submitted records indicates the patient being treated for left knee pain and osteoarthritis. Recent relevant subjective findings on 6/21/2013 included increased left knee pain and feeling it gives way with pain 5/10. There was also right knee pain that was constant and 8/10. The patient feels that he needs pain medications in the absence of right knee synovial injections. Objective findings on 6/21/2013 included tenderness to palpation at the medial and lateral knee joint lines bilaterally. Also, orthopedic testing was positive for patellar grind test and patellar femoral crepitus. There was no laxity detected in the knees. There did not appear to be any indication of any recent imaging studies performed or any certification or participation in therapeutic exercise programs or physical therapy.

### **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
- Utilization Review Determination by [REDACTED]
- Medical Records by [REDACTED] (dated 6/21/12 to 6/21/13)
- Lab records by [REDACTED] (dated 7/1/12 to 5/16/13)
- Medical Records by [REDACTED] (dated 6/21/13 and 6/28/13)
- Computerized Strength Test Report by [REDACTED], M.D. (dated 11/15/12)
- Orthopedic Reports by [REDACTED], M.D. (dated 11/15/12 and 12/31/12)
- Official Disability Guidelines (ODG) – Knee & Leg Chapter, BionCare Knee Device section

#### **1) Regarding the request for an off-the-shelf single upright brace with padding, liner, and a suspension wrap with a non-corrosive finish:**

##### 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 & Leg Chapter, BionCare Knee Device section, which is a medical treatment guideline that is not part of the California 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 was injured on 11/12/2007 and has experienced bilateral knee pain. The medical records received and reviewed indicate the employee has undergone multiple surgical interventions to both knees and requires Norco 10/325 to control knee pain. The records also indicate the employee has reached maximum medical improvement. A request was submitted for an off-the-shelf upright brace with padding, liner, and a suspension wrap with a non-corrosive finish.

The ODG indicates Bionicare knee devices are recommended as an option for patients in a therapeutic exercise program for osteoarthritis of the knee, who may be candidates for total knee arthroplasty but want to defer surgery. The medical records submitted and reviewed indicate the employee has chronic bilateral knee pain. However, the records do not indicate the employee has participated in a therapeutic exercise program for osteoarthritis of the knee. Additionally, the records submitted did not include any imaging studies that confirm the severity of osteoarthritis to the knee. The guideline criteria are not met and the documentation submitted does not support the request. The request for an off-

the-shelf single upright brace with padding, liner, and a suspension wrap with a non-corrosive finish is not medically necessary and appropriate.

**2) Regarding the request for 3 months of Bionicare knee device supplies:**

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 & Leg Chapter, BioniCare Knee Device section, which is a medical treatment guideline that is not part of the California 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 was injured on 11/12/2007 and has experienced bilateral knee pain. The medical records received and reviewed indicate the employee has undergone multiple surgical interventions to both knees and requires Norco 10/325 to control knee pain. The records also indicate the employee has reached maximum medical improvement. A request was submitted for 3 months of Bionicare knee device supplies.

The ODG indicates Bionicare knee devices are recommended as an option for patients in a therapeutic exercise program for osteoarthritis of the knee, who may be candidates for total knee arthroplasty but want to defer surgery. The medical records submitted and reviewed indicate the employee has chronic bilateral knee pain. However, the records do not indicate the employee has participated in a therapeutic exercise program for osteoarthritis of the knee. Additionally, the records submitted did not include any imaging studies that confirm the severity of osteoarthritis to the knee. The guideline criteria are not met and the documentation submitted does not support the request. The request for 3 months of Bionicare knee device supplies is not medically necessary and appropriate.

**3) Regarding the request for 3 months of Bionicare night wrap system supplies:**

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 & Leg Chapter, BioniCare Knee Device section, which is a medical treatment guideline that is not part of the California 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 was injured on 11/12/2007 and has experienced bilateral knee pain. The medical records received and reviewed indicate the employee has undergone multiple surgical interventions to both knees and requires Norco 10/325 to control knee pain. The records also indicate the employee has reached maximum medical improvement. A request was submitted for 3 months of Bionicare night wrap system supplies.

The ODG indicates Bionicare knee devices are recommended as an option for patients in a therapeutic exercise program for osteoarthritis of the knee, who may be candidates for total knee arthroplasty but want to defer surgery. The medical records submitted and reviewed indicate the employee has chronic bilateral knee pain. However, the records do not indicate the employee has participated in a therapeutic exercise program for osteoarthritis of the knee. Additionally, the records submitted did not include any imaging studies that confirm the severity of osteoarthritis to the knee. The guideline criteria are not met and the documentation submitted does not support the request. The request for 3 months of Bionicare night wrap system supplies 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

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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.