
Notice of Independent Medical Review Determination

Dated: 9/20/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/3/2013

12/26/2011

7/17/2013

CM13-0001787

- 1) MAXIMUS Federal Services, Inc. has determined the request for a stationary exercycle for home use **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a resistance chair with smoothrider attachment for both knees **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/17/2013 disputing the Utilization Review Denial dated 7/3/2013. 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 a stationary exercycle for home use **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a resistance chair with smooth rider attachment for both knees **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 3, 2013.

CLINICAL SUMMARY: This patient had an initial date of injury of 12/26/11. A note from 05/14/13 by Dr. [REDACTED] indicated that the patient was status post a right knee arthroscopy on 09/07/12 and he reported improvement in pain. The left continued to have medial joint pain. The recommendation was to withdraw the request for the neuroma resection.

A note from 03/27/13 indicated that the patient was injured when pushing a heavy load. He had a arthroscopic lateral capsulotomy, partial synovectomy, coblation of the LAX medial collateral ligament, and resection of the bucket-handle tear of the medial meniscus on the right.

A 03/05/13 note from Dr. [REDACTED] indicated that there was discussion of issues related to non-certification for additional surgery. Examination showed blood pressure of 138/98. The left knee showed no effusion, ligaments were stable, and range of motion was limited. The plan was to again request surgery on the left knee and also right ankle surgery.

A previous peer review also noted a history of surgery on the left knee on 05/07/12, which included a subtotal medial meniscectomy with partial synovectomy.

A previous peer review documented that there was a note from 01/23/13 by Dr. [REDACTED] which indicated the patient was 4 months post-operative for the left knee. The left knee was much improved. Examination showed full right knee range of motion and left knee had partial relief after injection of the neuroma. There was tenderness over the supramedial portal scar. The diagnoses included medial synovial plica, post-traumatic of the left knee, neuroganglioma of the the portal site, neuromas of the left knee, persistent meniscal tear or instability. The plan was for surgical exploration of the knee, surgery on the right ankle, schockwave therapy to the lateral right hand foot, transdermal ointments, and medications.

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
- California Medical Treatment Utilization Schedule (CMTUS)
- Medical Records from Dr. [REDACTED], MD (9/12/12 to 5/14/13)
- Medical Records from Dr. [REDACTED], MD (9/4/12 to 9/11/12)
- [REDACTED] Medical Records (6/26/12 to 6/28/12)
- Utilization Review Determination by [REDACTED] (7/03/12)

1) Regarding the request for a stationary exercycle for home use:

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

The Claims Administrator based its decision on the Official Disabilities Guidelines (ODG), Knee & Leg Chapter, Durable Medical Equipment 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 determined that the MTUS does not address the issue at dispute. 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 12/26/2011 and has experienced bilateral knee pain. The utilization review determination letter notes that the employee was diagnosed with bilateral knee strains and tear of the lateral meniscus to the right knee. Treatment has included ongoing physical therapy, restricted work, medications and knee bracing. A request for a stationary exercycle for home use was submitted.

The ODG indicates that exercise equipment is considered not primarily medical in nature and durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare definition of durable medical equipment. Durable medical equipment (DME) is defined as equipment that (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. An exercycle is not considered

primarily medical in nature. The request for stationery exercycle for home use is not medically necessary and appropriate.

2) Regarding the request for a resistance chair with smoothrider attachment for both knees:

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

The Claims Administrator based its decision on the Official Disabilities Guidelines (ODG), Knee & Leg Chapter, Durable Medical Equipment 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 determined that the MTUS does not address the issue at dispute. 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 12/26/2011 and has experienced bilateral knee pain. The utilization review determination letter notes that the employee was diagnosed with bilateral knee strains and tear of the lateral meniscus to the right knee. Treatment has included ongoing physical therapy, restricted work, medications and knee bracing. A request for a resistance chair with smoothrider attachment for both knees was submitted.

The ODG indicates exercise equipment is considered not primarily medical in nature and durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare definition of durable medical equipment. The medical records submitted do not support the use of a resistance chair and it is not clear as to what benefit this would achieve over and above what could be accomplished with simple home exercise. The request for a resistance chair with smoothrider attachment for both knees 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.