
Notice of Independent Medical Review Determination

Dated: 10/22/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/12/2013

7/23/1991

7/24/2013

CM13-0002949

- 1) MAXIMUS Federal Services, Inc. has determined the request for Right knee possible excision of loose body **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Physical therapy 2 times per week **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for an H-wave unit **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for a Cervical Traction Unit over the door **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Biofreeze **is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/24/2013 disputing the Utilization Review Denial dated 7/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/29/2013. 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 possible excision of loose body **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Physical therapy 2 times per week **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for an H-wave unit **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for a Cervical Traction Unit over the door **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Biofreeze **is 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 12, 2013:

"The dated of injury for this 51 year old female is 7/23/91. She has been treated for knee and cervical complaints. She had an AME by Dr. [REDACTED] on 10/12/10. At that time she has a history of locking and popping of the right knee. Exam revealed painful clicking of the right knee. The MRI of the right knee revealed a complex tear of the posterior horn of the medial meniscus. Dr. [REDACTED] notes indicated complaints of neck pain. There is no orthopedic or neurological exam in Dr. [REDACTED] notes."

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 7/24/2013)
- Utilization Review from [REDACTED] (dated 7/12/2013)
- Medical Records from [REDACTED], MD (dated 5/22/13)

1) Regarding the request for Right knee possible excision of loose body:

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) Indications for Surgery-Diagnostic arthroscopy which is not part of the Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer found MTUS did not address the issue at dispute and 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 July 23, 1991 to the upper back and right knee. The medical records submitted for review indicate the diagnoses of sprain/strain of the cervical spine, status post arthroscopic acromioplasty of the left shoulder with subsequent impingement and partial tear of the supraspinatus tendon, bilateral carpal tunnel syndrome, bilateral ulnar neuritis, left greater than right elbow, arthroscopic resection of medial synovial left knee, and tear of posterior horn of the medial meniscus, intrameniscal degeneration, lateral meniscus and interosseous lesion, right knee. Treatments to date include diagnostic imaging, physical therapy, left knee surgery, and medication management. The request is for right knee possible excision of loose body.

The Official Disability Guidelines (ODG) Indications for Surgery-Diagnostic arthroscopy recommend treating the loose body during an arthroscopy. The medical records submitted indicate that the arthroscopy of the knee was authorized, and if there is no loose body identified during arthroscopy, then the surgeon does not have to treat it. Thus, the request for right knee possible excision of loose body **is medically necessary and appropriate.**

2) Regarding the request for Physical therapy 2 times per week:

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 Treatment Guidelines (2009) pg 98-99 which is a part of Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance, and in addition based his/her decision on Knee Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 13) pg. 338, as well as The Postsurgical Treatment Guidelines, which are part of MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on July 23, 1991 to the upper back and right knee. The medical records submitted for review indicate the diagnoses of sprain/strain of the cervical spine, status post arthroscopic acromioplasty of the left shoulder with subsequent impingement and partial tear of the supraspinatus tendon, bilateral carpal tunnel syndrome, bilateral ulnar neuritis,

left greater than right elbow, arthroscopic resection of medial synovial left knee, and tear of posterior horn of the medial meniscus, intrameniscal degeneration, lateral meniscus and interosseous lesion, right knee. Treatments to date include diagnostic imaging, physical therapy, left knee surgery, and pain medication management. The request is for physical therapy 2 times per week.

MTUS guidelines allow 8-10 visits for myalgia, and neuralgia. MTUS/ACOEM guidelines state *“instruction in proper exercise technique is important and a few visits to a physical therapist can serve to educate the patient about an effective exercise program”* MTUS postsurgical guidelines for meniscal tears recommend 12 visits after a trial of 6 visits. Without speculation, the request as written is for 2 physical therapy (PT) visits in a week timeframe. Two PT visits in a week are within the MTUS chronic pain guidelines, they are within the MTUS clinical topic guidelines and within the MTUS post-surgical guidelines. The request for physical therapy 2 times per week **is medically necessary and appropriate.**

3) Regarding the request for an H-wave unit:

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 Treatment Guidelines pgs 117-118 which is a part of Medical Treatment Utilization Schedule (MTUS). 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 July 23, 1991 to the upper back and right knee. The medical records submitted for review indicate the diagnoses of sprain/strain of the cervical spine, status post arthroscopic acromioplasty of the left shoulder with subsequent impingement and partial tear of the supraspinatus tendon, bilateral carpal tunnel syndrome, bilateral ulnar neuritis, left greater than right elbow, arthroscopic resection of medial synovial left knee, and tear of posterior horn of the medial meniscus, intrameniscal degeneration, lateral meniscus and interosseous lesion, right knee. Treatments have included diagnostic imaging, physical therapy, left knee surgery, and medication management. The request is for an H-wave unit.

The MTUS Chronic Pain Medical Treatment Guidelines has specific criteria for a trial of H-wave. In this case, the clinical notes do not indicate evidence-based functional restoration, or initially recommended conservative care including physical therapy, medications, and transcutaneous electrical nerve stimulation (TENS) unit which are the requirements for a trial of H-wave. Therefore, the request for an H-wave unit **is not medically necessary and appropriate.**

4) Regarding the request for a Cervical Traction Unit over the door:

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) Neck chapter which is not part of the Medical Treatment Utilization

Schedule (MTUS). The Expert Reviewer based his/her decision on Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8) pg. 173, 181, which is part of MTUS, and in addition, 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 July 23, 1991 to the upper back and right knee. The medical records submitted for review indicate the diagnoses of sprain/strain of the cervical spine, status post arthroscopic acromioplasty of the left shoulder with subsequent impingement and partial tear of the supraspinatus tendon, bilateral carpal tunnel syndrome, bilateral ulnar neuritis, left greater than right elbow, arthroscopic resection of medial synovial left knee, and tear of posterior horn of the medial meniscus, intrameniscal degeneration, lateral meniscus and interosseous lesion, right knee. Treatments to date include diagnostic imaging, physical therapy, left knee surgery, and medication management. The request is for a cervical traction unit over the door.

MTUS/ACOEM guidelines on C-spine traction states, "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction... These palliative tools may be used on a trial basis but should be monitored closely. Furthermore, ACOEM lists "traction" under "Not Recommended" section for summary of recommendations and evidence table 8-8. The Official Disability Guidelines do not support traction unless the patient experiences radicular symptoms or radiculopathy. Based on the medical documentation reviewed, the employee does not have documented radiculopathy. Therefore, the over-the-door cervical traction unit **is not medically necessary and appropriate.**

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

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

The Claims Administrator based its decision on no indicated guidelines cited. The Expert Reviewer stated MTUS did not address the issue at dispute and based his/her decision on the Official Disability Guidelines (ODG-TWC), Low Back Chapter (online) as relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on July 23, 1991 to the upper back and right knee. The medical records submitted for review indicate the diagnoses of sprain/strain of the cervical spine, status post arthroscopic acromioplasty of the left shoulder with subsequent impingement and partial tear of the supraspinatus tendon, bilateral carpal tunnel syndrome, bilateral ulnar neuritis, left greater than right elbow, arthroscopic resection of medial synovial left knee, and tear of posterior horn of the medial meniscus, intrameniscal degeneration, lateral meniscus and interosseous lesion, right knee. Treatments to date include diagnostic imaging, physical therapy, left knee surgery, and medication management. The request is for Biofreeze.

The Official Disability Guidelines recommend Biofreeze as an optional form of cryotherapy for acute pain. The guidelines indicate that it takes the place of ice packs but lasts much longer before the reapplication. The medical records provided for the review indicate the employee's recent injury to the right foot is considered acute. Therefore, the request for Biofreeze **is 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

/mbg

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.