

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

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**Notice of Independent Medical Review Determination**

Dated: 10/29/2013

[REDACTED]

[REDACTED]

|                           |              |
|---------------------------|--------------|
| Employee:                 | [REDACTED]   |
| Claim Number:             | [REDACTED]   |
| Date of UR Decision:      | 7/17/2013    |
| Date of Injury:           | 7/11/2001    |
| IMR Application Received: | 7/24/2013    |
| MAXIMUS Case Number:      | CM13-0003057 |

- 1) MAXIMUS Federal Services, Inc. has determined the request for additional physical therapy 6 times **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for OrthoStim4 with supplies rental/purchase **is not 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 7/17/2013. 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 additional physical therapy 6 times **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for OrthoStim4 with supplies rental/purchase **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 determination dated 7/17/2013.

1. For the purpose of this review, the (L) knee will be addressed.
2. Diagnosis: P/O left knee arthroscopy 3/19/02 with partial medial meniscectomy, limited mid zone lateral meniscectomy, synovectomy. (Illegible) of the anterior femoral groove with residual degenerative joint disease.
3. The patient is a 58 year old male patient s/p injury 7/11/01, s/p (L) knee partial med-lat meniscectomy, synovectomy, chondroplasty 3/19/01, s/p (L) knee arthroscopy 3/19/02.
4. Discussion:
  - a) Patient has not completed physical therapy approved on 8/04/13

### 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 7/24/2013)
- Utilization Review Determination from [REDACTED] (dated 7/17/2013)
- Employee medical records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for additional physical therapy 6 times:**

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), pages 98-99, which is part of the Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG), Physical Therapy Guidelines, which is a medical treatment guideline that is not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the section of the MTUS 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 7/11/2001 to the left knee. The medical records provided for review indicate treatments have included left knee arthroscopy with meniscectomy. The request is for additional physical therapy 6 times.

The MTUS Chronic Pain Guidelines recommend fading of physical medicine treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. The medical records provided for review do not indicate functional improvement with the physical therapy already provided, and that eight sessions with the requested six additional visits will exceed guideline recommendations. The request for additional physical therapy 6 times **is not medically necessary and appropriate.**

**2) Regarding the request for OrthoStim4 with supplies rental/purchase:**

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, Neuromuscular Stimulation section, 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 based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 120-121, which are part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 7/11/2001 to the left knee. The medical records provided for review indicate treatments have included left knee arthroscopy with meniscectomy. The request is for OrthoStim4 with supplies rental/purchase.

The OrthoStim4 device contains Neuromuscular Electrical Stimulation Devices (NMES). The MTUS Chronic Pain Guidelines do not recommend NMES for chronic pain. The guidelines recommend a trial of interferential if there is diminished effectiveness with pain medications or side effects, or substance abuse. The medical records provided for review do not indicate that the employee has met any of the criteria for an interferential trial. The request for

OrthoStim4 with supplies rental/purchase **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.