
Notice of Independent Medical Review Determination

Dated: 11/21/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/15/2013

9/30/2003

7/26/2013

CM13-0003713

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Q-tech recovery system is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **On-Q pain pump is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **pair of crutches is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **half leg wrap purchase is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **universal therapy wrap is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **continuous passive motion machine is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/26/2013 disputing the Utilization Review Denial dated 7/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/8/2013. 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 **Q-tech recovery system is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **On-Q pain pump is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **pair of crutches is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **half leg wrap purchase is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **universal therapy wrap is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **continuous passive motion machine 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.

CLINICAL SUMMARY:

Disclaimer: No clinical summary was provided by the claims administrator

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 of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Q-tech recovery system:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not provide any evidence-based guideline to support its decision.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (latest version), Knee and Leg Chapter Continuous flow Cryotherapy,, which is not a part of the MTUS.

Rationale for the Decision:

The employee reported a work-related injury on 09/01/2003; specific mechanism of injury not stated. Operative report dated 05/10/2013 reports the employee underwent left knee arthroscopic subtotal re-resection of the lateral meniscus of the left knee, synovectomy of 3 compartments, diagnostic arthroscopy, placement of a pain pump, and application of Bledsoe brace under the care of the provider. The provider documents on clinical note dated 05/13/2013, the patient was seen in clinic postoperatively to arthroscopic removal of the posterior horn of the lateral meniscus that was redrawn and return. There was a large fat that was removed. The provider documents removal of the pain pump was rendered on this date. The provider documented the patient was to continue utilization of the CPM and ice machine postoperatively. The provider documents on clinical note dated 05/20/2013 the employee again was seen in clinic, was to continue utilization of a CPM and cold therapy machine postoperatively. The request is for the Q-tech recovery system.

The current request previously received an adverse determination due to a lack of submitted documentation. The current request is not supported. After a review of the medical records provided for review, the provider does not offer duration of treatment for this modality. Official Disability Guidelines indicates this modality "is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use." Given the lack of documented duration of frequency, the patient was instructed to utilize this modality submitted with this request, the request is not supported. Guidelines also indicate mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapies. **The request for Q-tech recovery system is not medically necessary and appropriate.**

2) Regarding the request for On-Q pain pump:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not provide any evidence-based guideline to support its decision.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG) (latest version), Knee and Leg Chapter, Postoperative pain pump, which is not a part of the MTUS.

Rationale for the Decision:

The employee reported a work-related injury on 09/01/2003; specific mechanism of injury not stated. Operative report dated 05/10/2013 reports the employee underwent left knee arthroscopic subtotal re-resection of the lateral meniscus of the left knee, synovectomy of 3 compartments, diagnostic arthroscopy, placement of a pain pump, and application of Bledsoe brace under the care of Dr. [REDACTED]. The provider documents on clinical note dated 05/13/2013, the patient was seen in clinic postoperatively to arthroscopic removal of the posterior horn of the lateral meniscus that was redrawn and return. There was a large fat that was removed. The provider documents removal of the pain pump was rendered on this date. The provider documented the patient was to continue utilization of the CPM and ice machine postoperatively. The provider documents on clinical note dated 05/20/2013 the patient again was seen in clinic, was to continue utilization of a CPM and cold therapy machine postoperatively. The request is for On-Q pain pump.

The current request previously received an adverse determination due to a lack of submitted documentation. Official Disability Guidelines indicate, "This pain pump was intended to help considerably with postoperative discomfort and is removed by the patient or the family 2 to 3 days after surgery. There is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre or postoperative pain control utilizing oral intramuscular or intravenous measures." The medical records provided for review notes evidence the employee is being treated for postoperative arthroscopic meniscal repair. The provider did not offer a rationale in the clinical notes reviewed to support the employee utilizing pain pump postoperatively for pain complaints, as the clinical notes did not evidence the employee was utilizing additional opioids orally. Given that this modality is not supported via guidelines, **the request for On-Q pain pump is not medically necessary and appropriate.**

3) Regarding the request for pair of crutches:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not provide any evidence-based guideline to support its decision.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (latest version), Knee and Leg Chapter, Walking aids, which is not a part of the MTUS.

Rationale for the Decision:

The employee reported a work-related injury on 09/01/2003; specific mechanism of injury not stated. Operative report dated 05/10/2013 reports the employee underwent left knee arthroscopic subtotal re-resection of the lateral meniscus of the left knee, synovectomy of 3 compartments, diagnostic arthroscopy, placement of a pain pump, and application of Bledsoe brace under the care of Dr. [REDACTED]. The provider documents on clinical note dated 05/13/2013, the patient was seen in clinic postoperatively to arthroscopic removal of the posterior horn of the lateral meniscus that was redrawn and return. There was a large fat that was removed. The provider documents removal of the pain pump was rendered on this date. The provider documented the patient was to continue utilization of the CPM and ice machine postoperatively. The provider documents on clinical note dated 05/20/2013 the patient again was seen in clinic, was to continue utilization of a CPM and cold therapy machine postoperatively. The request is for a pair of crutches.

The current request previously received an adverse determination due to a lack of submitted documentation. The provider documents the employee underwent arthroscopic meniscal repair on 05/10/2013. Official Disability Guidelines indicate, "Almost half of patients with knee pain possess a walking aid." The review of the medical records submitted for review evidences the employee presents status post an arthroscopic repair of the meniscus. Utilization of crutches would be supported postoperatively for this patient to assist with ambulation. **The request for crutches is medically necessary and appropriate.**

4) Regarding the request for half leg wrap purchase:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not provide any evidence-based guideline to support its decision.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer

based his/her decision on the Official Disability Guidelines (lastest version), Knee and Leg Chapter, continuous flow Cryotherapy, which is not a part of the MTUS.

Rationale for the Decision:

The employee reported a work-related injury on 09/01/2003; specific mechanism of injury not stated. Operative report dated 05/10/2013 reports the employee underwent left knee arthroscopic subtotal re-resection of the lateral meniscus of the left knee, synovectomy of 3 compartments, diagnostic arthroscopy, placement of a pain pump, and application of Bledsoe brace under the care of Dr. [REDACTED]. The provider documents on clinical note dated 05/13/2013, the patient was seen in clinic postoperatively to arthroscopic removal of the posterior horn of the lateral meniscus that was redrawn and return. There was a large fat that was removed. The provider documents removal of the pain pump was rendered on this date. The provider documented the patient was to continue utilization of the CPM and ice machine postoperatively. The provider documents on clinical note dated 05/20/2013 the patient again was seen in clinic, was to continue utilization of a CPM and cold therapy machine postoperatively. The request is for a half leg wrap purchase.

The current request previously received an adverse determination due to a lack of submitted documentation. Official Disability Guidelines indicates this modality “is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use.” After a review of the medical records submitted for review and given the lack of documented duration of frequency, the employee was instructed to utilize this modality submitted with this request, the request is not supported. Guidelines also indicate mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapies. **The request for half leg wrap purchase is not medically necessary and appropriate.**

5) Regarding the request for universal therapy wrap:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not provide any evidence-based guideline to support its decision.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers’ Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (lastest version), Knee and Leg Chapter, criteria for the use of continuous passive motion devices, which is a part of the MTUS.

Rationale for the Decision:

The employee reported a work-related injury on 09/01/2003; specific mechanism of injury not stated. Operative report dated 05/10/2013 reports the employee underwent left knee arthroscopic subtotal re-resection of the lateral meniscus of the left knee, synovectomy of 3 compartments, diagnostic arthroscopy, placement of a pain pump, and application of Bledsoe brace under the care of

the provider. The provider documents on clinical note dated 05/13/2013, the patient was seen in clinic postoperatively to arthroscopic removal of the posterior horn of the lateral meniscus that was redrawn and return. There was a large fat that was removed. The provider documents removal of the pain pump was rendered on this date. The provider documented the patient was to continue utilization of the CPM and ice machine postoperatively. The provider documents on clinical note dated 05/20/2013 the patient again was seen in clinic, was to continue utilization of a CPM and cold therapy machine postoperatively. The request is for universal wrap therapy.

The current request previously received an adverse determination due to a lack of submitted documentation. The current request is not supported. After a review of the medical records submitted the provider does not offer duration of treatment for this modality. The current request is not supported as this modality is recommended for specific postoperative patients, meniscal repair is not indicated for use of a continuous passive motion device postoperatively. Furthermore, the provider does not render rationale for duration of frequency of treatment for this modality. Official Disability Guidelines indicate, "Routine home use of continuous passive motion has minimal benefit, recommended as indicated below for in hospital use or for home use in patients at risk of a stiff knee. Based on demonstrated compliance and measured improvements, the beneficial effects over regular PT may be small." Given that the employee presents status postoperative arthroscopic meniscectomy and without a supported rationale evidenced by the provider, **the request for universal therapy wrap is not medically necessary and appropriate.**

6) Regarding the request for continuous passive motion machine:

The Claims Administrator did not provide any evidence-based guidelines to support its decision.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (latest version), Knee and Leg Chapter, Criteria for the use of continuous passive motion devices, which is not a part of the MTUS.

Rationale for the Decision:

The employee reported a work-related injury on 09/01/2003; specific mechanism of injury not stated. Operative report dated 05/10/2013 reports the employee underwent left knee arthroscopic subtotal re-resection of the lateral meniscus of the left knee, synovectomy of 3 compartments, diagnostic arthroscopy, placement of a pain pump, and application of Bledsoe brace under the care of the provider. The provider documents on clinical note dated 05/13/2013, the patient was seen in clinic postoperatively to arthroscopic removal of the posterior horn of the lateral meniscus that was redrawn and return. There was a large fat that was removed. The provider documents removal of the pain pump was rendered on this date. The provider documented the patient was to continue

utilization of the CPM and ice machine postoperatively. The provider documents on clinical note dated 05/20/2013 the patient again was seen in clinic, was to continue utilization of a CPM and cold therapy machine postoperatively. The request is for continuous passive motion machine.

The current request previously received an adverse determination due to a lack of submitted documentation. After a review of the documents submitted for review, the current request is not supported. The provider does not offer duration of treatment for this modality. The current request is not supported as this modality is recommendation for specific postoperative patients, meniscal repair is not indicated for use of a continuous passive motion device postoperatively. Furthermore, the provider does not render rationale for duration of frequency of treatment for this modality. Official Disability Guidelines indicate, "Routine home use of continuous passive motion has minimal benefit, recommended as indicated below for in hospital use or for home use in patients at risk of a stiff knee. Based on demonstrated compliance and measured improvements, the beneficial effects over regular PT may be small." Given that the patient presents status postoperative arthroscopic meniscectomy and without a supported rationale evidenced by the provider, **the request for continuous passive motion 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,

Paul Manchester, MD, MPH
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.