

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 10/24/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/19/2013
Date of Injury: 12/21/2010
IMR Application Received: 7/26/2013
MAXIMUS Case Number: CM13-0003934

- 1) MAXIMUS Federal Services, Inc. has determined the request for right unicompartmental knee arthroplasty **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for an assistant surgeon **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a seven (7) day post op at skilled nursing facility **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for a walker purchase **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for cold therapy unit purchase **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for post op physical therapy three (3) times per week for four (4) weeks **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for right knee MRI **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 7/19/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/1/2013. 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 unicompartmental knee arthroplasty **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for an assistant surgeon **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a seven (7) day post op at skilled nursing facility **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for a walker purchase **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for cold therapy unit purchase **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for post op physical therapy three (3) times per week for four (4) weeks **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for right knee MRI **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 18, 2013:

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According to the records made available for review, this is a 52-year-old male patient. The patient most recently (6/24/13) presented with significant limitations due to his knee pain; the

pain impacts his social and work life; the pain has made him depressed; he describes the pain as sharp, burning, moderate to severe (depending on activity) and constant; the patient is currently in so much pain and is so limited in his activities. Physical examination revealed BMI of 29, tenderness to palpation of the medial joint space bilaterally; range of motion of the knee is unrestricted; positive Apley's and McMurray's bilaterally; x-rays done on 6/21/13 revealed almost bone on bone on the medial joint space bilaterally; there are no other significant joint changes; there is significant medial joint arthritis bilaterally. There is also documentation that bilateral knees MRIs were performed, however, the formal reports and findings were not available for review. Current diagnoses include medial joint arthritis. Treatment to date includes Synvisc injections, medication, and activity modification. Treatment requested is right unicompartmental knee arthroplasty, assistant surgeon, 7 day stay post-op at skilled nursing facility, DME: walker purchase, cold therapy unit purchase, PT post op 3x4, MRI right knee.

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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 7/26/13)
- Utilization Review Determination from [REDACTED] (dated 7/19/13)
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for right unicompartmental knee arthroplasty : Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines, (ODG), Knee Section, Indications for Surgery, Knee Arthroplasty, a medical treatment guideline (MTG), not part of the MTUS. 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), Knee Section, Indications for Surgery, Knee Arthroplasty, a medical treatment guideline (MTG), not part of the MTUS.

Rationale for the Decision:

The employee was injured on 12/21/2010. The submitted and reviewed medical records indicate that the employee has had MRIs, X-rays, Synvisc injections, medications and activity modification. The most recent medical record, dated 6/24/2013, indicated that the employee was having constant bilateral, moderate to severe knee pain. A request was submitted for right unicompartmental knee arthroplasty, an assistant surgeon, seven (7) day post op at skilled nursing facility, one walker purchase, a cold therapy unit purchase, post op physical therapy (3) three times four (4) , and a right knee MRI.

The Official Disability Guidelines recommend a unicompartmental knee arthroplasty if only one of the compartments is affected. The guideline criteria for a knee arthroplasty includes: conservative care consisting of supervised PT or home exercise program and medications, plus documentation of limited range of

motion, and complaints of night joint pain, no pain relief with conservative care, and documentation of current functional limitations when the patient is over 50 years of age and has a body mass index of less than 35 when there is documentation of significant loss of chondral clear space in at least 1 of 3 compartments. The records indicate the employee is performing a home exercise program and walking program, is noted to have been treated with Synvisc injections in the past, and is utilizing oral NSAIDs and topical NSAIDs with minimal improvement in pain. MRI and X-rays report severe osteoarthritis of the medial joint line with bone on bone, tricompartmental osteoarthritis of the right knee, and there are complaints of ongoing joint pain. The records indicate the employee is over 50 years of age and does have a body mass index of 29; however, there is no documentation of limited range of motion. As such, the requested right knee unicompartmental arthroplasty does not meet guideline recommendations. The request for a right unicompartmental knee arthroplasty **is not medically necessary and appropriate.**

2) Regarding the request for an assistant surgeon:

Since the right unicompartmental knee arthroplasty is not medically necessary, none of the associated services are medically necessary and appropriate.

Regarding the request for a seven (7) day post op at skilled nursing facility

Since the right unicompartmental knee arthroplasty is not medically necessary, none of the associated services are medically necessary and appropriate

3) Regarding the request for a walker purchase :

Since the right unicompartmental knee arthroplasty is not medically necessary, none of the associated services are medically necessary and appropriate

4) Regarding the request for cold therapy unit purchase :

Since the right unicompartmental knee arthroplasty is not medically necessary, none of the associated services are medically necessary and appropriate.

5) Regarding the request for post op physical therapy three (3) times per week for four (4) weeks:

Since the right unicompartmental knee arthroplasty is not medically necessary, none of the associated services are medically necessary and appropriate

6) Regarding the request for right knee MRI :

Since the right unicompartmental knee arthroplasty is not medically necessary, none of the associated services are 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.