

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/30/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/23/2013
Date of Injury: 3/20/2010
IMR Application Received: 8/1/2013
MAXIMUS Case Number: CM13-0005980

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The underlying date of injury in this case is 03/20/2010. The patient's diagnoses include lumbar sprain, rule out internal derangement of both knees, and a left shoulder subacromial impingement syndrome. As of 06/03/2013, the patient's diagnoses included lumbar strain with L5-S1 disc protrusion, left shoulder subacromial impingement syndrome and equivalent clavicular arthrosis, right knee medial meniscus tear, and nonspecific left knee arthralgia. The current request is a retrospective request for this kit of 06/19/2013. Initial physician review noted that the request was originally non-certified given a request for current subjective and objective findings regarding the condition of the patient's knees. Information in the medical records regarding a knee rehabilitation kit indicates that this includes graduated resistance bands, a water weight wrap, a knee hot-and-cold compression wrap, a pressure-relieving exercise mat, and an instruction program complete with exercise program.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. 1 knee rehab kit is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Physical Medicine, which is part of the MTUS.

The Physician Reviewer's decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines section on Physical Medicine recommends "Active therapy requires an internal effort by the individual to complete a specific exercise or task... Allow for the fading of treatment frequency plus active self-directed home physical medicine." The treatment guidelines, therefore, recommend an individualized rehabilitation/exercise program. The medical records

provided for review indicate that the requested treatment appears to be a generic treatment program rather than equipment and exercise instructions individualized for the employee. **The request for 1 knee rehab kit, is not medically necessary and appropriate.**

/js

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.

[REDACTED]

CM13-0005980