

<b>Case Number:</b>	CM13-0056033		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	11/15/2011
<b>Decision Date:</b>	08/07/2014	<b>UR Denial Date:</b>	11/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in New York and Texas. 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

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

The injured worker is a 38 year old male who sustained an injury on 11/15/11. No specific mechanism of injury was noted. The injured worker had prior right knee arthroscopy and was followed for continuing complaints of pain in the left knee and bilateral wrists. Prior treatment included the use of medications including Dilaudid. As of 11/04/13 the injured worker reported continuing complaints of left knee pain that had worsened over time. The injured worker reported that medications were working well. The injured worker was recommended to continue with a home exercise program. Physical examination noted restricted range of motion in the left knee to 150 degrees flexion. There was normal extension. Tenderness to palpation at the medial joint line was identified. No focal motor weakness was noted in the lower extremities. The injured worker was recommended to continue with narcotic medications pending left knee surgical intervention. Dilaudid was increased to 2mg twice daily for severe pain. The clinical record on 11/22/13 noted persistent complaints of pain in the left knee. Physical examination continued to note tenderness in the medial joint line with positive McMurray sign. Range of motion was intact and there was no evidence of instability. Magnetic resonance imaging reportedly showed internal derangement with posterior medial meniscal tear. No imaging studies were available for review. The submitted request including left knee arthroscopy with assistant surgeon; pre-operative electrocardiogram, x-ray, urinalysis, complete blood count, and chemistry panel; physical examination; 12 sessions of post-operative physical therapy; cold therapy unit; and magnetic resonance image of the right wrist were non-certified by utilization review on 11/14/13.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left knee arthroscopy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345.

**Decision rationale:** The injured worker had medial meniscal tear in the left knee however no imaging studies were available for review. The clinical documentation noted evidence of joint line tenderness and positive McMurray signs; however, without corresponding findings on imaging this reviewer would not have recommended this request as medically appropriate. Furthermore the clinical documentation did not discuss any specific conservative treatment for the left knee such as physical therapy or anti-inflammatories. The only medication noted in the clinical records was ongoing use of narcotics such as Dilaudid. Given the lack of clinical documentation regarding conservative treatment and absence of updated imaging studies confirming pathology to the left knee that would benefit from surgical intervention, this reviewer would not have recommended this request as medically appropriate.

**Assistant surgeon: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: American Association of Orthopaedics Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Preoperative EKG: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Pre-operative testing, General.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Preoperative Xray: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Pre-operative testing, General.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Preoperative Urinalysis: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Pre-operative testing, General.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Preoperative Complete Blood Count and Chem Panel: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Pre-operative testing, General.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Preoperative Physical Examination: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation In regards to the request for a pre-operative physical exam, this reviewer would not have recommended this request as medically necessary. The surgical request for the left knee was not felt to be medically indicated. Therefore there would be

no requirement for a pre-operative physical exam. As such this reviewer would not have recommended this request as medically necessary.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

## **12 Postoperative physical therapy sessions: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

## **Cold Therapy unit: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Continuous Cold Therapy Unit.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

## **MRI of the right wrist: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for imaging-Magnetic resonance imaging (MRI).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

**Decision rationale:** In regards to the request for a magnetic resonance image of the right wrist, this reviewer would not have recommended this imaging request as medically necessary. The last evaluation for the injured worker did not discuss any pertinent findings of the right wrist that would support imaging. There were no plain film radiographs available for review that were primarily non-diagnostic in nature. Given the lack of any recent objective findings regarding potential instability or pathology in the right wrist and as there were no plain films radiographs of the right wrist, this reviewer would not have recommended this request as medically appropriate.

