

<b>Case Number:</b>	CM14-0133274		
<b>Date Assigned:</b>	08/22/2014	<b>Date of Injury:</b>	08/05/2003
<b>Decision Date:</b>	10/03/2014	<b>UR Denial Date:</b>	08/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/21/2014

### 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 Occupational Medicine 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 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:

Patient is a 56 year-old female with date of injury 08/05/2003. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 07/23/2014, lists subjective complaints as pain in the right shoulder, both wrists, both hands, low back, right trochanteric area, and both knees. Objective findings: Examination of the right knee revealed tenderness along the knee on the right and the left. There was no weakness to resisted function. Knee extension was 120 degrees on the right and 180 degrees on the left and flexion is 90 degrees on the right and 135 degrees on the left. Compression test was positive, more right than the left. Negative inhibition test. Positive patellar tilt test bilaterally. Diagnosis: 1. Impingement syndrome, right shoulder 2. Carpal tunnel syndrome, bilaterally 3. Wrist inflammation, bilaterally 4. Wrist joint inflammation, bilaterally 5. Trochanteric bursitis, right 6. Discogenic lumbar condition with radiculitis 7. Internal derangement of knee, left 8. Internal derangement of knee, right 9. Depression, sleep disorder, anxiety, weight gain over 100 pounds, constipation, GI irritation, and hypertension. Surgical history includes right shoulder surgery, 10/18/2004, right knee surgery, 07/17/2006, right wrist surgery, 04/27/2009, and an additional right knee surgery on 03/28/2011. MRI of the left knee, 09/13/2013 revealed flap tear in the body and posterior horn of the medial meniscus. Other treatments include activity modification, medication management to include NSAIDs, muscle relaxants, analgesics, opioids, topical medications, injection therapy, hyaluronic injections, physical therapy, TENS unit, back brace, cold/heat application, and multiple surgical procedures.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Standing X-Ray of the right knee (antero- posterior and lateral views): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**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 (Acute & Chronic), Radiography (x-rays)

**Decision rationale:** Physical exam failed to reveal any evidence of joint effusion, swelling, ecchymosis, deformity, increased warmth, or abrasion/laceration. The findings documented on the chart note failed to meet the minimum criteria stated in the Official Disability Guidelines for x-ray imaging of the knee. Therefore, the request is not medically necessary.

**Preoperative Electrocardiograph: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**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 - Lumbar & Thoracic (Acute & Chronic), Preoperative electrocardiogram (ECG)

**Decision rationale:** The Official Disability Guidelines state that electrocardiogram is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. The patient will require no preoperative workup however, because her knee surgery is considered not medically necessary. Therefore, the request is not medically necessary.

**Pre operative chest x-ray: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**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 - Lumbar & Thoracic (Acute & Chronic), Preoperative testing, general

**Decision rationale:** The Official Disability Guidelines state that preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, and urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. The patient will require no

preoperative workup however, because her knee surgery is not medically necessary. Therefore, the request is not medically necessary.

**21 day rental of a [REDACTED] Unit and an Extension Lock Splint Range of Motion Knee Brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross Clinical UM Guideline, Durable Medical Equipment, Guideline #: CG-DME-10, Last Review Date: 02/13/2014

**Decision rationale:** According to the Blue Cross Clinical UM Guideline for Durable Medical Equipment, durable medical equipment is considered medically necessary when all of a number of criteria are met; however, the patient will require no postoperative durable medical equipment, because her knee surgery is not medically necessary. Therefore, the request is not medically necessary.

**Template Measurement:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**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 (Acute & Chronic), Knee joint replacement

**Decision rationale:** Template measurement is sometimes used in the preoperative planning stage prior to total knee replacement. The patient will require no preoperative template measurement however, because her knee surgery is not medically necessary. Therefore, the request is not medically necessary.