

Case Number:	CM14-0152045		
Date Assigned:	09/22/2014	Date of Injury:	02/26/2014
Decision Date:	10/30/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/18/2014

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 & 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 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 51 year old male with a date of injury on 2/26/2014. The injured worker was performing his customary duties when he got involved in a motor vehicular accident and sustained injuries to his neck, back, and left knee. He was initially treated at the emergency room of [REDACTED] on February 28, 2014 where x-ray exam of his lumbar spine was obtained revealing no significant abnormality. He was subsequently referred to [REDACTED] for further treatment. From March 4, 2014 to April 18, 2014, he was treated with medications, physical therapy, knee brace, activity modification. A magnetic resonance imaging (MRI) scan of the left lower extremity without contrast was obtained on March 31, 2014 and the findings revealed (a) medial meniscus subtle free-edge radial tear of the posterior horn; (b) lateral meniscus free-edge radial tear of the body; (c) medial femoral condyle and patellar low grade chondral loss and fissuring; (d) moderate amount of semimembranous-tibial collateral ligament bursal fluid suggesting bursitis. On April 22, 2014, the injured worker presented to the treating physician for an initial comprehensive evaluation regarding his left knee. On physical examination, the injured worker walked with a slightly antalgic gait. An examination of his left knee demonstrated trace effusion, pain with full extension, discomfort with flexion, tenderness over the medial and lateral joint lines, and positive provocative meniscal exam. Corticosteroid injection was administered. The injured worker returned on May 20, 2014 with complaints of pain in his left knee, neck, shoulders, and low back. An examination of his cervical spine revealed restricted range of motion with pain elicited upon extension and lateral bending, as well as tenderness over the right mid cervical spine extending to his right scapula and trapezium. Thoracolumbar spine examination showed limited range of motion with pain produced upon extension. An examination of the lower extremities revealed mild antalgic gait on the left side, mild effusion on the left knee, tender plica, and tender medial joint. In his follow-up visit on June

3, 2014, the injured worker complained of moderate to severe symptoms localized to his left knee with associated clicking, stiffness, swelling, and tenderness. On examination, the left knee was tender with a possible plica and tenderness was present over the medial joint. He was reevaluated on June 17, 2014 with complaint of 6/10 pain level in his left knee with associated swelling, stiffness, tenderness warmth, and burning pain. A physical examination of the left knee demonstrated tender plica, painful motion, and mild effusion. In his subsequent visit on July 8, 2014, his complaint remained essentially unchanged. A physical examination of the left knee showed large plica which was very tender, mild effusion, and tender lateral joint. On July 29, 2014, his symptoms were still localized to his left knee with associated swelling, burning and stabbing pain, popping, numbness and tenderness. No orthopedic examination was done. Surgery to the left knee was finally approved.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chest x-ray 8/15/14: 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, Preoperative testing, general

Decision rationale: According to the Official Disability Guidelines (ODG), chest radiography is reasonable for injured workers at risk of postoperative pulmonary complications if the results would change perioperative management. Moreover, the guidelines stipulate that the decision to order preoperative tests should be guided by the injured worker's clinical history, comorbidities, and physical examination findings. Since consultation with internal medicine for preoperative clearance was already approved, result of this examination is therefore first warranted to determine the appropriateness of proceeding with chest x-ray. Therefore the request is not medically necessary.

Pre-op labs 8/15/14: 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, Preoperative lab testing

Decision rationale: The Official Disability Guidelines (ODG) specifies that laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. Moreover, it notes that the decision to order preoperative tests should be guided by the injured worker's clinical history, comorbidities, and physical examination findings. Since

consultation with internal medicine for preoperative clearance was already approved, result of this examination is therefore first warranted to determine the appropriateness of proceeding with preoperative laboratory testing. Therefore the request is not medically necessary.

Pre- op EKG 8/15/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 2007 American College of Cardiology (ACC)/ American Heart Association (AHA) 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, Preoperative electrocardiogram (ECG)

Decision rationale: Although the injured worker is considered at an intermediate cardiac risk for undergoing orthopedic surgery, he however has no other known cardiac risk factors. Moreover, since consultation with internal medicine for preoperative clearance was already approved, result of this examination is first warranted to determine the appropriateness of proceeding preoperative electrocardiogram. The Official Disability Guidelines (ODG) states that preoperative electrocardiogram is recommended for injured workers undergoing high-risk surgery and those undergoing intermediate-risk surgeries who have additional risk factors. In addition, it stipulates that preoperative electrocardiographies (ECGs) in injured workers without known risk factors for coronary disease, regardless of age, may not be necessary. Therefore the request is not medically necessary.