

<b>Case Number:</b>	CM14-0159835		
<b>Date Assigned:</b>	10/29/2014	<b>Date of Injury:</b>	05/17/2007
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	09/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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 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 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:

This is a 55-year-old male with a 5/17/07 injury date. He was hit by a pipe while at work and knocked over. In a follow-up dated 9/5/14, subjective complaints included 8/10 constant sharp left knee pain, radiation to the thigh and down the leg with shooting and stabbing pain, and use of a walker and cane. The knee pain was increased with repetitive kneeling and squatting, and there was difficulty going up and down the stairs. There was swelling, popping, and loss of strength in the leg, and occasional locking and buckling. Objective findings included antalgic gait, muscle atrophy of the thigh, no deformity or effusion or swelling, medial and lateral joint line tenderness, positive McMurray's and Clark's tests, and no rotary instability. There was left knee crepitation noted with range of motion. The provider noted the patient is a poor historian, was unable to work, and weighed 300 pounds after a previous weight of 360 pounds. The knee In a 9/25/14 follow-up, the provider disagreed with the recent UR decision and stated that the patient had already lost close to 40-50 pounds, was still showing signs of knee instability and pain associated with meniscus tear, and believed the patient should undergo the arthroscopy to extend the life of the knee prior to any possible knee replacement surgery. A 9/24/07 left knee MRI showed a complex tear of the medial meniscus and mild irregularity of the articular cartilage in the medial compartment. Diagnostic impression: left knee arthritis, meniscus tear. Treatment to date: left knee cortisone injections, physical therapy, medications. A UR decision on 9/15/14 denied the request for left knee arthroscopy on the basis that there are coexisting osteoarthritic changes in the knee, in addition to the meniscus tears. Furthermore, in an 11/19/09 evaluation by [REDACTED], it was stated that the patient was not a good candidate for surgery given the morbid obesity. The requests for pre-op medical clearance, crutches, post-op physical therapy, Keflex, Norco, and knee brace were denied because the associated surgical procedure was not certified.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **1 LEFT KNEE ARTHROSCOPY:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Knee and leg chapter--Meniscectomy.

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) states that arthroscopic partial meniscectomy usually has a high success rate for cases where there is clear evidence of a meniscus tear, symptoms other than simply pain, clear signs of a bucket handle tear on examination, and consistent findings on magnetic resonance imaging (MRI). In addition, Official Disability Guidelines (ODG) criteria for meniscectomy include failure of conservative care. In this case, there appears to be sufficient evidence to reverse the prior UR decision. The patient meets several criteria that support going forward with arthroscopic meniscectomy. These criteria include the presence of mechanical symptoms such as clicking, popping, and locking, the presence of swelling, the clear presence of meniscal tear on MRI, and the failure of appropriate conservative care. Objective findings on exam include positive McMurray's and joint line tenderness. The patient's weight has come down from 360 pounds to 300 pounds. In addition, even though meniscectomy will not improve upon the underlying arthritic changes, it can still substantially improve the overall function of the knee even when arthritis is present. It is notable that the patient's left knee arthritis does not appear very severe on the imaging studies, and there is no deformity on exam. Therefore, the request for 1 left knee arthroscopy is medically necessary.

### **1 PRE-OP MEDICAL CLEARANCE:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery general information and ground rules, California official medical fee schedule

**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 EKG and Lab testing. Other Medical Treatment Guideline or Medical Evidence: ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery.

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) does not address this issue. Official Disability Guidelines (ODG) states that pre-op testing 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. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography 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. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. The ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery state that in the asymptomatic patient, a more extensive assessment of history and physical examination is warranted in those individuals 50 years of age or older. In this case, the patient meets criteria for pre-operative medical clearance, and the associated surgical procedure was certified. Therefore, the request for 1 pre-op medical clearance is medically necessary.

### **1 PAIR OF CRUTCHES: Overturned**

**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 and Leg Chapter--Walking aids

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) does not address this issue. Official Disability Guidelines (ODG) states that walking aids are recommended, with almost half of patients with knee pain possessing a walking aid. In this case, the patient will require crutches in the post-op period, and the associated surgical procedure was certified. Therefore, the request for 1 pair of crutches is medically necessary.

### **12 POST-OP 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.

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) recommends 12 physical therapy sessions over 12 weeks after arthroscopic meniscectomy. The request for 12 sessions is warranted given the certification of the associated surgical procedure. Therefore, the request for 12 post-op physical therapy sessions is medically necessary.

### **UNKNOWN PRESCRIPTION OF KEFLEX: 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: Bert JM, Giannini D, Nace L. Antibiotic prophylaxis for arthroscopy of the knee: is it necessary? Arthroscopy. 2007 Jan;23(1): 4-6

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) and Official Disability Guidelines (ODG) do not address this issue. Peer-reviewed literature states that there is no value in administering antibiotics before routine arthroscopic surgery to prevent joint sepsis. A case can be made for administering a short course of oral antibiotics in the post-op period given the patient's obesity. However, the request cannot be certified because the quantity and dosage was not specified. Therefore, the request for unknown prescription of Keflex is not medically necessary.

**UNKNOWN PRESCRIPTION OF NORCO:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Page(s): 79-81.

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) states that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time, such as in a postoperative setting. Although a short course of oral opioids is clinically indicated for this patient, the request for Norco cannot be approved because the dosage, duration, and quantity were not specified. Therefore, the request for unknown prescription of Norco is not medically necessary.

**1 KNEE BRACE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339-340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Knee and Leg Chapter--Knee brace.

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) states that a knee brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability although its benefits may be more emotional than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually unnecessary. In all cases, braces need to be properly fitted and combined with a rehabilitation program. ODG states that prefabricated knee braces may be appropriate for certain indications, such as knee instability, reconstructed ligament, articular defect repair, or tibial plateau fracture.

In this case, the patient does not appear to meet criteria for post-op knee brace. Therefore, the request for 1 knee brace is not medically necessary.