

<b>Case Number:</b>	CM14-0034027		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	10/31/2012
<b>Decision Date:</b>	12/18/2014	<b>UR Denial Date:</b>	03/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/18/2014

### 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 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 43 year old male with a 10/31/12 injury date. He injured his left knee when he stepped in a hole while pushing a wheelbarrow. A left knee arthroscopy with meniscectomy was certified as part of the recent UR decision. A left knee MRI on 11/19/13 revealed a medial meniscus tear. In a 6/9/14 note, the patient reported "doing very good" and was ready to return to work with restrictions. He had undergone left knee arthroscopy on 4/3/14. Objective findings included left knee flexion to 135 degrees, extension to neutral, minimal swelling, minimal joint line tenderness, and healed surgical scars. Diagnostic impression: left knee medial meniscus tear. Treatment to date: physical therapy, medications, arthroscopy. A UR decision on 3/4/14 denied the request for assistant surgeon because "this is a simple case that does not require an assistant." The request for post-operative physical therapy 2 times per week for 4 weeks (8 visits) was modified to allow for 2 times per week for 3 weeks (6 visits) to be in keeping with the MTUS concept of an initial course of therapy equal to half the maximum (12 visits). The request post-operative interferential (IF) unit rental for 14 days was denied because the efficacy of IF treatment has not been established. The request for post-operative cold unit rental for 14 days was modified to allow for a 7-day rental based upon the guideline recommendations. The request for post-operative continuous passive motion (CPM) rental for 14 days was denied, because there was insufficient documentation supporting the request. The request for post-operative clearance to include lipid panel, Comprehensive Metabolic Panel (CMP), Complete Blood Count (CBC), PT, PTT, Urinalysis (UA), chest x-ray, and Electrocardiogram (EKG) was modified to allow for everything except for the lipid panel, because the patient's lipids do not apply to ability to undergo safe anesthesia.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Assistant Surgeon: 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 Other Medical Treatment Guideline or Medical Evidence: American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics

**Decision rationale:** CA MTUS and ODG do not address this issue. American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics states on the role of the First Assistant: According to the American College of Surgeons: "The first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The first assistant provides aid in exposure, hemostasis, and other technical functions, which will help the surgeon carry out a safe operation and optimal results for the patient. The role will vary considerably with the surgical operation, specialty area, and type of hospital. "The first assistant's role has traditionally been filled by a variety of individuals from diverse backgrounds. Practice privileges of those acting as first assistant should be based upon verified credentials reviewed and approved by the hospital credentialing committee (consistent with state laws)." In general, the more complex or risky the operation, the more highly trained the first assistant should be. Criteria for evaluating the procedure include: anticipated blood loss, anticipated anesthesia time, anticipated incidence of intraoperative complications, procedures requiring considerable judgmental or technical skills, anticipated fatigue factors affecting the surgeon and other members of the operating team, and procedures requiring more than one operating team. In limb reattachment procedures, the time saved by the use of two operating teams is frequently critical to limb salvage. It should be noted that reduction in costly operating room time by the simultaneous work of two surgical teams could be cost effective. The use of an assistant surgeon is ultimately under the discretion of the operating surgeon. Therefore, the request for assistant surgeon is medically necessary.

**Post operative physical therapy 2 times a week for 4 weeks ( 8 visits): Overturned**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** CA MTUS supports 12 physical therapy sessions over 12 weeks after arthroscopic meniscectomy. The current request for 8 sessions over 4 weeks is within the guideline criteria. Therefore, the request for post operative physical therapy 2 times a week for 4 weeks (8 visits) is medically necessary.

**Post operative interferential (IF) unit rental 14 days: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Therapy Page(s): 118-120.

**Decision rationale:** CA MTUS states that interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and knee pain. However, there is no discussion of exceptional factors that would necessitate the use of an IF unit after a medically indicated surgery for a meniscal tear. Therefore, the request for post-operative IF unit rental 14 days is not medically necessary.

**Post operative cold unit rental 14 days: Upheld**

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

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

**Decision rationale:** CA MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended as an option after surgery but not for nonsurgical treatment. Post operative use generally may be up to 7 days, including home use. However, the current request is for 14 days, which does not meet the guideline criteria. Therefore, the request for post-operative cold unit rental 14 days is not medically necessary.

**Post operative continuous passive motion (CPM) rental times 14 days: Upheld**

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

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

**Decision rationale:** CA MTUS does not address this issue. ODG criteria for the use of continuous passive motion devices for up to 21 days include total knee arthroplasty; anterior cruciate ligament reconstruction; open reduction and internal fixation of tibial plateau or distal

femur fractures involving the knee joint. However, given the diagnosis of meniscal tear, the use of a CPM machine is not appropriate. Therefore, the request for post-operative CPM rental times 14 days is not medically necessary.

**Post Operative clearance to include CMP Lipid Panel, CBC, PT, PTT, Urinalysis, chest Xray and 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 EKG and Lab testing and Other Medical Treatment Guideline or Medical Evidence: ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery

**Decision rationale:** CA MTUS does not address this issue. 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 surgeries 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. However, the results of a lipid panel are not relevant in determining a patient's safety while undergoing anesthesia and is therefore not appropriate. Therefore, the request for post-operative clearance to include CMP Lipid Panel, CBC, PT, PTT, Urinalysis, chest X-ray and EKG is not medically necessary.