

Case Number:	CM14-0186591		
Date Assigned:	11/14/2014	Date of Injury:	09/07/2010
Decision Date:	01/05/2015	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	11/10/2014

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 Physical Medicine and Rehabilitation has a subspecialty in Pain 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:

The injured worker is a 36 year-old male with an original date of injury of September 7, 2010. The mechanism of injury was patient losing balance and twisting his knee at work. The industrially related diagnoses include right knee ACL reconstruction, left knee pain secondary to compensation, and status post right knee arthroscopic surgeries. The patient was taking Norco and Anaprox for pain control. He has had two right knee arthroscopic surgeries for ACL ligament reconstruction and partial lateral meniscectomy on January 7, 2011 and August 31, 2011 respectively, and a remote history of right knee ACL reconstruction in 2003. The patient has ongoing pain despite treatments to date, he underwent a MR arthrogram of the right knee which revealed a radial flap tear of the posterior horn of the right medial meniscus, needing an arthroscopic partial right medial meniscectomy, chondroplasty, and debridement based on orthopedics evaluation on 8/18/2014. The disputed issue is a requested for pre-operative medical clearance. A utilization review on October 21, 2014 has non-certified this request. The rationale for denial was lack of documentation supporting the need for pre-operative clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Pre-Operative Medical Clearance: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck Chapter, Preoperative lab testing, Preoperative electrocardiogram (ECG)

Decision rationale: Official Disability Guidelines (ODG), Neck Chapter, Preoperative electrocardiogram (ECG) 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. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Preoperative ECGs in patients without known risk factors for coronary disease, regardless of age, may not be necessary. Preoperative and postoperative resting 12-lead ECGs are not indicated in asymptomatic persons undergoing low-risk surgical procedures. Low risk procedures (with reported cardiac risk generally less than 1%) include endoscopic procedures; superficial procedures; cataract surgery; breast surgery; & ambulatory surgery. An ECG within 30 days of surgery is adequate for those with stable disease in whom a preoperative ECG is indicated. (Fleisher, 2008) (Feely, 2013) (Sousa, 2013) Criteria for Preoperative electrocardiogram (ECG): High Risk Surgical Procedures:- These are defined as all vascular surgical procedures (with reported cardiac risk often more than 5%, which is the combined incidence of cardiac death and nonfatal myocardial infarction), and they include: - Aortic and other major vascular surgery; & - Peripheral vascular surgery.- Preoperative ECG is recommended for vascular surgical procedures. Intermediate Risk Surgical Procedures:- These are defined as procedures with intermediate risk (with reported cardiac risk generally 1-5%), and they include: - Intraoperative and intrathoracic surgery; - Carotid endarterectomy; - Head and neck surgery; & - Orthopedic surgery, not including endoscopic procedures or ambulatory surgery.- Preoperative ECG is recommended for patients with known CHD, peripheral arterial disease, or cerebrovascular disease- Preoperative ECG may be reasonable in patients with at least 1 clinical risk factor: - History of ischemic heart disease; - History of compensated or prior HF; - History of cerebrovascular disease, diabetes mellitus, or renal insufficiency. Low Risk Surgical Procedures:- These are defined as procedures with low risk (with reported cardiac risk generally less than 1%), and they include: - Endoscopic procedures; - Superficial procedures; - Cataract surgery; - Breast surgery; & - Ambulatory surgery.- ECGs are not indicated for low risk procedures. Official Disability Guidelines (ODG), Neck Chapter, Preoperative lab testing Recommended as indicated below. Preoperative additional tests are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. (Feely, 2013) (Sousa, 2013) Criteria for Preoperative lab testing:- Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material.- Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure.- Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus.- In patients with diagnosed

diabetes, A1C testing is recommended only if the result would change perioperative management.- A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated.- Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. Due to the lack of documentation of what constitutes the "pre-operative medical clearance", such as EKG, internal medicine consult, or labs, this request cannot be approved at this time. The requesting provider should specify in a progress note of why pre-operative medical clearance is ordered and any significant comorbidities or medical history that may be relevant.