

<b>Case Number:</b>	CM15-0100427		
<b>Date Assigned:</b>	06/03/2015	<b>Date of Injury:</b>	02/06/2003
<b>Decision Date:</b>	07/09/2015	<b>UR Denial Date:</b>	04/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Indiana, Oregon  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 60-year-old male, who sustained an industrial injury on February 6, 2003. He reported injuries of neck, head, back, and knee. The injured worker was diagnosed as having a left knee medial meniscus tear and left knee chondromalacia. On July 9, 2012, an electro diagnostic studies revealed left lumbar 4-5 radiculopathy. On August 27, 2014, x-rays of the left knee were unremarkable. On January 9, 2015, an MRI of the left knee revealed a tear of the medial meniscus and mild to moderate chondromalacia of the medial compartment and patella. Treatment to date has included yoga, physical therapy, a single point cane, left knee viscosupplementation injections, and medications including short-acting and long acting pain, muscle relaxant, anti-epilepsy, proton pump inhibitor, and non-steroidal anti-inflammatory. On April 1, 2015, the injured worker complains of constant aching pain of the left knee with complete numbness of the left foot. The physical exam of the left knee revealed active range of motion of 120 degrees of flexion and 5 degrees of extension, passive range of motion of 130 degrees of flexion and 0 degrees of extension, and tenderness over the medication joint line, lateral joint line, and patellar tendon. There was no instability with manipulation or weight bearing, and mildly decreased strength of the hamstrings, hip flexors, and quads. The sensation of the left lower extremity was intact. The treatment plan includes a pre-op clearance medicine consultation for a left knee arthroscopy medial meniscectomy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Pre-Operative Clearance Medicine Consult: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7, Independent Medical Examinations and Consultations, page 127.

**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.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states, "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. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Preoperative ECG in patients without known risk factor for coronary artery disease, regardless of age, may not be necessary. CBC is recommended for surgeries with large anticipated blood loss. Creatinine is recommended for patient with renal failure. Electrocardiography is recommended for patients undergoing high-risk surgery and that undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the most comprehensive history of medical problems found in the review on the office visits 12/9/14, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 60 year old without significant comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore, the determination is not medically necessary.