

<b>Case Number:</b>	CM15-0107693		
<b>Date Assigned:</b>	06/12/2015	<b>Date of Injury:</b>	12/17/2013
<b>Decision Date:</b>	08/18/2015	<b>UR Denial Date:</b>	05/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/04/2015

### 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: Illinois, California, Texas  
 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:

This injured worker is a 46-year-old male who sustained an industrial injury on 12/17/13. The mechanism of injury was not documented. Past medical history was positive for asthma, diabetes mellitus, hypertension and mitral valve prolapse. Conservative treatment was documented to include hyaluronic acid injections, corticosteroid injection, home exercise program, medications, bracing, and activity modification without sustained improvement. The 3/27/15 right knee MRI impression documented findings consistent with prior partial medial meniscectomy without evidence of re-tear. There was popliteal tendon advanced proximal tendinopathy with edema and thickening. There was tricompartmental chondromalacia with full thickness non-displaced fissures of the lateral patellar cartilage and lateral tibial cartilage. There was mild distal tendinopathy of the quadriceps and distal patellar tendon. The lateral meniscus was reported within normal limits. The 5/1/15 treating physician report cited continued right knee pain with catching and instability. Right knee exam documented 1+ effusion, pain at the lateral joint line, and positive crepitus with range of motion. Imaging was reviewed and showed lateral meniscus truncation and lateral femoral condyle degenerative joint disease. The treating physician report reported that imaging showed tricompartmental arthritis but did not show a clear meniscal tear, however he had mechanical symptoms. Authorization was requested for right knee surgery, arthroscopy, chondroplasty, and meniscectomy, surgical assistant, pre-operative electrocardiogram (EKG), and cold therapy unit and pad. The 5/18/15 utilization review non-certified the right knee surgery, arthroscopy, chondroplasty, and meniscectomy and associated

surgical requests as there was evidence of tricompartmental osteoarthritis, and no clear clinical or imaging evidence of meniscus tear or full thickness chondral defect.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Right knee surgery, arthroscopy, chondroplasty, meniscectomy:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 334-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee meniscectomy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Knee and Leg: Chondroplasty; Meniscectomy.

**Decision rationale:** The California MTUS guidelines state that surgical consideration may be indicated for patients who have activity limitation for more than one month and failure of exercise programs to increase range of motion and strength of the musculature around the knee. Guidelines support arthroscopic partial meniscectomy for cases in which there is clear evidence of a meniscus tear including symptoms other than simply pain (locking, popping, giving way, and/or recurrent effusion), clear objective findings, and consistent findings on imaging. The Official Disability Guidelines (ODG) criteria for meniscectomy include conservative care (exercise/physical therapy and medication or activity modification) plus at least two subjective clinical findings (joint pain, swelling, feeling or giving way, or locking, clicking or popping), plus at least two objective clinical findings (positive McMurray's, joint line tenderness, effusion, limited range of motion, crepitus, or locking, clicking, or popping), plus evidence of a meniscal tear on MRI. The ODG criteria for chondroplasty include evidence of conservative care (medication or physical therapy), plus joint pain and swelling, plus effusion or crepitus or limited range of motion, plus a chondral defect on MRI. Guideline criteria have been met. This injured worker presents with persistent right knee pain with mechanical symptoms of clicking and instability. Clinical exam findings are consistent with reported imaging evidence of a full thickness chondral defect and plausible meniscal pathology. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Given the persistent mechanical symptoms despite comprehensive non-operative treatment, this request is medically necessary.

**Surgical assistant:** 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 Centers for Medicare and Medicaid services, Physician Fee Schedule: Assistant Surgeons, <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

**Decision rationale:** The California MTUS guidelines do not address the appropriateness of assistant surgeons. The Center for Medicare and Medicaid Services (CMS) provide direction relative to the typical medical necessity of assistant surgeons. The Centers for Medicare & Medicaid Services (CMS) has revised the list of surgical procedures which are eligible for assistant-at-surgery. The procedure codes with a 0 under the assistant surgeon heading imply that an assistant is not necessary; however, procedure codes with a 1 or 2 implies that an assistant is usually necessary. For this requested surgery, CPT codes 29880, there is a 1 in the co-surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

**Pre-operative electrocardiogram (EKG):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.medscape.com/medline/abstract/8441296](http://www.medscape.com/medline/abstract/8441296), Medscape, Preoperative testing.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3): 522-38.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines state that an EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. Guideline criteria have been met. This injured worker has significant risk factors and history of cardiac disease that support the medical necessity of pre-procedure EKG. Therefore, this request is medically necessary.

**Durable medical equipment: CTU and pad:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cold/heat packs.

**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: Continuous flow cryotherapy.

**Decision rationale:** The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after knee surgery for up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.

