

<b>Case Number:</b>	CM15-0162929		
<b>Date Assigned:</b>	08/31/2015	<b>Date of Injury:</b>	11/19/2012
<b>Decision Date:</b>	09/30/2015	<b>UR Denial Date:</b>	08/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/19/2015

### 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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 47 year old female who reported an industrial injury on 11-19-2012. Her diagnoses, and or impression, were noted to include: pain in lower leg joint; and meniscal tear of the knee. Recent magnetic imaging studies of the right knee were done on 7-6-2015, noting some abnormal findings. Her treatments were noted to include; activity restrictions; injection therapy; medication management; and rest from work. The progress notes of 6-24-2015 noted a follow-up visit for continued pain in the right knee following the wearing off of her injection, which was said to have been helpful and allowed her to walk better. Objective findings were noted to include that her injection provided some relief but had worn off; that she was not in therapy and was taking her medications; and "id: bucket handle medial meniscus". The physician's requests for treatments were noted to include a right knee arthroscopy with pre-operative clearance.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient right knee arthroscopy, lateral meniscectomy, debridement as indicated:**

Overtured

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

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

**Decision rationale:** Per the MTUS guidelines arthroscopic partial meniscectomy usually has a high success rate for cases in which there is clear evidence of a meniscus tear-symptoms other than simply pain (locking, popping, giving way, recurrent effusion); clear signs of a bucket handle tear on examination (tenderness over the suspected tear but not over the entire joint line, and perhaps lack of full passive flex ion); and consistent findings on MRI. However, patients suspected of having meniscal tears, but without progressive or severe activity limitation, can be encouraged to live with symptoms to retain the protective effect of the meniscus. If symptoms are lessening, conservative methods can maximize healing. In patients younger than 35, arthroscopic meniscal repair can preserve meniscal function, although the recovery time is longer compared to partial meniscectomy. Arthroscopy and meniscus surgery may not be equally beneficial for those patients who are exhibiting signs of degenerative changes. In this case, the injured worker is diagnosed with a right knee meniscus tear (bucket handle tear). MRI of the right knee confirms this finding and she has significant pain and limitations with the knee. The request for outpatient right knee arthroscopy, lateral meniscectomy, debridement as indicated is determined to be medically necessary.

**Pre-operative medical clearance:** 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 Perioperative protocol. Health care protocol. National Guideline Clearinghouse (NGC), Rockville MD, Agency for Healthcare Research and Quality (AHRQ).

**Decision rationale:** The MTUS guidelines and the ODG do not address pre-operative clearance; therefore, alternative guidelines were consulted. Per the cited guidelines, abnormal findings (noted on the preoperative basic health assessment) are results that require further evaluation to assess and optimize any surgical/anesthesia risk or cares. Further evaluation may be as simple as asking a few more questions, performing further physical examination, or ordering a laboratory or radiological exam. More in-depth evaluations may be needed, such as a consultation or cardiac stress testing. Most laboratory and diagnostic tests (e.g., hemoglobin, potassium, coagulation studies, chest x-rays, electrocardiograms) are not routinely necessary unless a specific indication is present and may be beyond the scope of this protocol. Other abnormal findings, though relevant to the patient's general health, may not have any impact on the planned procedure or the timing of the procedure. Evaluation and management of these incidental findings should follow standard medical practice and are beyond the scope of the protocol. Chest x-ray is recommended if the patient has signs or symptoms suggesting new or unstable cardiopulmonary disease. The following are recommended for preoperative EKG: 1) Perform

electrocardiogram for all patients age 65 and over, within one year prior to procedure, 2) Electrocardiograms are not indicated, regardless of age, for those patients having cataract surgery, 3) Preoperative electrocardiograms are not recommended for patients undergoing other minimal risk procedures, unless medical history/assessment indicate high-risk patient. These guidelines recommend that patients should be identified perioperatively if they are an active carrier or have history of MDRO, such as MRSA, but laboratory screening without significant history is not supported by these guidelines. The injured worker is a 47 year old female who is not reported to have significant history to support perioperative testing. The request for pre-operative medical clearance is determined to not be medically necessary.