

Case Number:	CM15-0080867		
Date Assigned:	05/01/2015	Date of Injury:	01/10/2012
Decision Date:	07/07/2015	UR Denial Date:	03/31/2015
Priority:	Standard	Application Received:	04/27/2015

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:

The injured worker is a 23-year-old female who sustained an industrial injury on 1/10/12. Injury occurred when she was bouncing on a trampoline with children and felt a twist and tearing feeling in her left knee. Past medical history was positive for depression. Social history was positive for smoking. She underwent left knee anterior cruciate ligament (ACL) reconstruction and meniscectomy on 11/27/12. The 5/9/13 left knee MRI impression post-operative changes involving the medial meniscus with increased signal intensity in the posterior horn suggesting a new tear. Findings were suggestive of a new medial meniscus tear. There were post-operative changes of partial lateral meniscectomy with a small new tear in the body of the lateral meniscus. There was superomedial plica, more noticeable than previous exam, and thickened patellar tendon consistent with probable post-operative fibrotic changes. The 3/11/15 left knee x-rays documented evidence of past ACL reconstruction with interference screw no longer in the tibial tunnel and migrated into the joint space. There was some chondromalacia patella. The 3/11/15 treating physician report cited constant left knee pain increased with prolonged walking or weight bearing. Static standing was limited to 10 minutes. Functional difficulty was noted with quick motion, jumping, jogging, or lateral movement. There was tenderness over the screw site on the anterior knee. Conservative treatment had included surgical treatment, post-operative physical therapy, and non-steroidal anti-inflammatory drugs. Physical exam documented left knee active range of motion 0-120 degrees, with tenderness over the medial patellar facet, pes anserine bursa and medial joint line. Patellar grind, McMurray's, and Apley compression tests were positive. There was normal strength. The diagnosis included left knee meniscus tear, patellofemoral syndrome, pes bursitis, plica, and painful hardware. Authorization was requested for left knee arthroscopy with removal of hardware, bone graft, meniscectomy and

chondroplasty, post op medications including Percocet, Keflex, Ambien and Zofran, physical therapy, ice therapy, pre-operative clearance and pre-op studies. The 3/31/15 utilization review certified the request for left knee arthroscopy with removal of hardware, bone graft, meniscectomy, and chondroplasty. The requests for medicine consult, pre-operative clearance, and pre-operative studies (chest x-ray, EKG, CBC, Chem 7, and PT/PTT/INR) were non-certified as there was no rationale presented to support the medical necessity of these pre-operative services. The request for Ambien 10 mg # 30 was modified to Ambien 10 mg #14 consistent with guidelines. The request for Zofran 4 mg #30 was modified to Zofran 4 mg #10 consistent with guidelines. The request for ice therapy/cold compression therapy was modified to 7 day rental of a cold therapy unit consistent with guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medicine consult and pre-operative clearance: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.guideline.gov/content.aspx?id=48408, Perioperative protocol, Health care protocol.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

Decision rationale: The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Middle-aged females have known occult increased medical/cardiac risk factors. Guideline criteria have been met based on smoking status, long-term use of non-steroidal anti-inflammatory drugs, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

Pre-operative studies including CSR, EKG, and labs including CBC, Chem 7, and PT/PTT/INR: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Preoperative testing, general.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. 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. Routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. Guideline criteria have been met based on smoking history, long-term use of non-steroidal anti-inflammatory drugs, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Insomnia treatment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Zolpidem (Ambien).

Decision rationale: The California Medical Treatment Utilization Schedule does not make recommendations relative to zolpidem or insomnia treatment. The Official Disability Guidelines recommend the use of Ambien as first-line medication for the short term (two to six week) treatment of insomnia. The short term post-operative use of this medication is reasonable for possible post-operative insomnia. The 3/31/15 utilization review modified this request to Ambien 10 mg #14. There is no compelling rationale presented for the use of this medication beyond 2 weeks. Therefore, this request is not medically necessary.

Zofran 4mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Antiemetics (for opioid nausea), Ondansetron (Zofran).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice guidelines for postanesthetic care.

Decision rationale: The California MTUS and Official Disability Guidelines do not provide recommendations for anti-emetics for post-operative use. Practice guidelines for post-anesthetic care support the use of anti-emetics, such as Zofran, for patients when indicated but do not recommend routine pharmacologic prophylaxis of nausea and vomiting. The 3/31/15 utilization review modified this request to Zofran 4 mg #10. There are no specific indications for the prophylactic prescription of anti-emetics for this patient. There is no compelling rationale to support the medical necessity of additional medication certification. Therefore, this request is not medically necessary.

Ice therapy and cold compression therapy unit 3 times a week: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, 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 and Leg: Cold compression therapy; Game Ready accelerated recovery system; Continuous flow cryotherapy.

Decision rationale: The California MTUS is silent regarding cold therapy units and cold compression therapy. The Official Disability Guidelines generally recommend continuous flow cryotherapy for up to 7 days as an option for patients undergoing knee arthroscopy. Guidelines state that there are no published high quality studies on the Game Ready device or any other combined cold and compression system to support the increased efficacy over cryotherapy alone. The 3/31/15 utilization review decision recommended partial certification of a cold therapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold compression unit or cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.