

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0095224 | | |
| Date Assigned: | 07/25/2014 | Date of Injury: | 07/17/2003 |
| Decision Date: | 09/25/2014 | UR Denial Date: | 05/28/2014 |
| Priority: | Standard | Application Received: | 06/23/2014 |

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 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 51-year-old female, who reported an injury on 07/17/2003 due to an unknown mechanism. The diagnoses were a medial meniscus tear, pain knee, patella chondromalacia. The past treatments were physical therapy. The diagnostic studies included an MRI of the right knee. The MRI revealed postoperative changes of the medial meniscectomy; abnormal horizontal signal of the posterior horn and the medial meniscus (this appeared to be granulation tissue as opposed to a new tear); fraying and surgical changes of the lateral meniscus; tricompartmental osteoarthritis. There was a small joint effusion, Baker cyst, and mild patellar and quadriceps tendinosis. The surgical history included a partial lateral meniscus and chondroplasty surgery of the right knee and appendectomy and gallbladder. The physical examination on 07/17/2014 revealed complaints of right knee achiness. An examination of the right knee revealed surgical wounds were clean, dry, and intact with no signs of infection. The calf was soft and non-tender and no medications were reported. The treatment plan was for physical therapy. The rationale and Request for Authorization were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-operative laboratory work including CBC (complete blood count), CMP (complete metabolic panel), PT (prothrombin time), and INR (international normalized ratio):

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), TWC.

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, Preoperative Testing, general.

Decision rationale: The Official Disability Guidelines preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risks, 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. Routine preoperative tests are defined as those done in the absence of any specific clinical indication or purpose and typically include a panel of blood tests, urine tests, chest radiography, and an electrocardiogram. These tests are performed to find latent abnormalities, such as anemia or silent heart disease that could impact how, when, or whether the planned surgical procedure and concomitant anesthesia are performed. It is unclear whether the benefits accrued from responses to true positive tests outweigh the harms of false positive preoperative tests and, if there is a net benefit, how this benefit compares to the resource utilization required for testing. An alternative to routine preoperative testing for the purpose of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings. However, the relative effect on patient and surgical outcomes, as well as resource utilization, of these 2 approaches is unknown. The latest AHRQ Comparative Effectiveness Research, on the benefits and harms of routine preoperative testing, concludes that, except for cataract surgery, there is insufficient evidence comparing routine and per protocol testing. It was not reported in the document submitted that the injured worker was anemic or on any type of medication, such as Coumadin, to support the need of a CBC or a prothrombin time testing. The medical necessity for a complete metabolic panel was not reported. Therefore, the request is not medically necessary.