

<b>Case Number:</b>	CM15-0127797		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	07/31/2013
<b>Decision Date:</b>	08/27/2015	<b>UR Denial Date:</b>	06/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2015

### 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 51 year old male, who sustained an industrial injury on 7/31/2013. He reported falling to the ground, feeling a pulling sensation in his back and feeling a popping sensation in his left knee. Diagnoses have included right knee enthesopathy, right knee chondromalacia, internal derangement of right knee and medial meniscal tear of right knee. Treatment to date has included left knee surgery, physical therapy, steroid injection, medication and acupuncture. Magnetic resonance imaging (MRI) of the right knee from January 2015 showed oblique tear of the posterior horn of the medial meniscus. According to the progress report dated 4/16/2015, the injured worker complained of moderate to severe knee pain on the right side. The knee pain interfered with all activities of daily living. He reported that his knee made grinding sounds and locked up. He stated that his right knee condition was progressively getting worse since the injury. He was unable to walk more than ten to fifteen minutes before stopping and sitting due to severe right knee pain. He was using a right knee brace. Exam of the right knee revealed severe pain on attempted full extension with failure to lock the right knee on full extension. There was marked localized and regional tenderness diffusely around the right knee joint line. There was mild to moderate effusion on the medial and anterior aspect of the right knee. There was mild to moderate crepitus noted on flexion and extension of the right knee associated with some tenderness upon manual patellar pressure. Authorization was requested for right knee arthroscopic medial meniscal repair, partial meniscectomy, and associated services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Knee Arthroscopic Medial Meniscal Repair, Partial Meniscectomy: Overturned**

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

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

**Decision rationale:** CAMTUS/ACOEM Chapter 13 Knee Complaints, pages 344-345, states regarding meniscus tears, "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)." According to ODG Knee and Leg section, Meniscectomy section, states indications for arthroscopy and meniscectomy include attempt at physical therapy and subjective clinical findings, which correlate with objective examination and MRI. In this case there is an MRI showing a tear, the patient has failed multiple non-surgical therapies such as injection, PT, acupuncture and bracing. There are mechanical symptoms and findings on exam. The request has fulfilled all guideline criteria and is medically necessary.

**Pre-op Medical Clearance: Upheld**

**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](http://www.guideline.gov/content.aspx).

**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 those undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 51 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore the request is not medically necessary.

**Pre-op Lab Work: Laboratory Blood Work: 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); Low Back 9updated 5/15/15), Online Version.

**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 those undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 51 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore the request is not medically necessary.

**Associated services: 3 day in patient stay: 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 (updated 5/5/15), Online Version, Hospital Length of Stay.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of length of stay following knee arthroscopy. According to ODG Knee and Leg, outpatient is the target for knee arthroscopy. In this case the 3 day request exceeds the recommended ambulatory procedure and the request is therefore not medically necessary and appropriate.

**Associated Services: EKG: 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); Low Back 9(updated 5/15/15), Online Version.

**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 those undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 51 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore the request is not medically necessary.

**Associated services: Chest X-ray:** 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); Low Back 9(updated 5/15/15), Online Version.

**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 those undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 51 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore the request is not medically necessary.

**Post-op Rehabilitation Stay at Skilled Nursing Facility: 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 (updated 5/5/15), Online Version, Skilled Nursing Facility (SNF) Care, criteria for skilled nursing facility care.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of acute rehab or skilled nursing length of stay. According to the ODG, Knee and Leg, Skilled nursing facility LOS (SNF), "Recommend up to 10-18 days in a skilled nursing facility (SNF) or 6-12 days in an inpatient rehabilitation facility (IRF), as an option but not a requirement, depending on the degree of functional limitation, ongoing skilled nursing and / or rehabilitation care needs, patient ability to participate with rehabilitation, documentation of continued progress with rehabilitation goals, and availability of proven facilities, immediately following 3-4 days acute hospital stay for arthroplasty." The decision for acute rehab or skilled nursing facility will be dependent on the outcome following the knee replacement and objective criteria during the acute inpatient admission. As there is no evidence of the results of the rehab process during the inpatient admission, the request is not medically necessary.

**Post-op Occupational Therapy 2 x 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

**Decision rationale:** According to the CA MTUS/Post Surgical Treatment Guidelines, Knee Meniscectomy, page 24, 12 visits of therapy are recommended after arthroscopy with partial meniscectomy over a 12-week period. The guidelines recommend initially of the 12 visits to be performed. As the request exceeds the initial allowable visits, the request is not medically necessary.