

Case Number:	CM13-0057565		
Date Assigned:	12/30/2013	Date of Injury:	01/03/2013
Decision Date:	05/20/2014	UR Denial Date:	11/01/2013
Priority:	Standard	Application Received:	11/25/2013

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 Orthopedic Surgery 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 claimant is a 44-year-old female who was injured on January 3, 2013, sustaining a left ankle fracture that resulted in open reduction internal fixation. Recent clinical records for review indicate a December 2, 2013 follow-up report indicating that the claimant was interested in having hardware removed. She was noted to be doing well. There was no acute indication of hardware failure or pain. A physical examination showed improved function, with radiographs demonstrating good alignment. The surgical request for hardware removal, as well as the need for preoperative medical clearance to include laboratory testing and postoperative physical therapy was recommended for further treatment based on appeal of Utilization Review, the procedure was approved per carrier. Specific clinical request in this case is for the preoperative clearance to include laboratory testing and EKG for the above mentioned intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

NE (1) PREOPERATIVE CLEARANCE TO INCLUDE LABS AND ELECTROCARDIOGRAM (EKG): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Citation: SURGERY GENERAL INFORMATION AND GROUND RULES, CALIFORNIA OFFICIAL MEIDCAL FEE SCHEDULE, 1999 EDITION, PAGES 92-93, and the NATIONAL GUIDELINES

CLEARINGHOUSE. The Claims Administrator also cited the Non-MTUS Citation:
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MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Citation: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004), CHAPTER 7, INDEPENDENT MEDICAL EXAMINATIONS AND CONSULTATIONS, PAGE 127. The Expert Reviewer also cited the Non-MTUS Citation: OFFICIAL DISABILITY GUIDELI

Decision rationale: The ACOEM Guidelines indicate that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. The Official Disability Guidelines indicate that preoperative lab testing is recommended. The Guidelines also indicate that the decision to order preoperative tests should be guided by the patient's clinical history, co-morbidities, and physical examination findings. A preoperative electrocardiogram (EKG) is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgeries, who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Review of the claimant's clinical records fails to demonstrate any evidence of underlying co-morbidity particularly from a cardiac standpoint that would necessitate the acute need of the assessment in question. It is documented that the claimant did well with the previous and initial surgical process at the beginning of January. There was no specific change in the claimant's clinical course or medical history, which would fail to necessitate the specific request at this time.