

Case Number:	CM14-0006763		
Date Assigned:	02/07/2014	Date of Injury:	05/24/2012
Decision Date:	07/22/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/15/2014

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 Orthopedic Surgery has a subspecialty in 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 patient is a 36-year-old male who has submitted a claim for left shoulder acromioclavicular joint osteoarthritis associated with an industrial injury date of May 24, 2012. Medical records from 2012-2014 showed the patient complained of chronic left shoulder pain, grade 9/10 in severity. There was associated popping and burning sensation with activity and the pain was aggravated with overhead activities. Physical examination showed tenderness over the left acromioclavicular joint line with restricted range of motion of the left shoulder due to pain. Impingement sign was positive and motor strength was 4/5 on the left shoulder. Sensation was intact. MRI of the left shoulder revealed mild degenerative changes of the acromioclavicular joint with small quantity of subacromial/subdeltoid fluid, and no tendon or labral tears. Treatment to date has included medications, physical therapy, chiropractic therapy, transcutaneous electrical nerve stimulation (TENS) unit, extracorporeal shock wave therapy (ESWT), acupuncture, cortisone injections, activity modification, cervical spine surgery, and left shoulder arthroscopy and subacromial decompression. Utilization review, dated December 27, 2013, modified the request for preoperative medical clearance to the left shoulder with preoperative laboratory testing because guidelines do not support more extensive preoperative clearance for a patient who is under 50 and has no documented comorbidities.

IMR ISSUES, DECISIONS AND RATIONALES

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

PREOPERATIVE 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 Official Disability Guidelines (ODG), Low Back Chapter, Preoperative Testing, General as well as Non-MTUS ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care For Noncardiac Surgery.

Decision rationale: CA MTUS does not specifically address preoperative clearance. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that preoperative testing can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Electrocardiography (ECG) is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications. Preoperative lab testing should generally be done to confirm a clinical impression and tests should affect the course of treatment. In addition, ACC/AHA 2007 guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery states that in the asymptomatic patient, a more extensive assessment of history and physical examination is warranted in those individuals 50 years of age or older. In this case, the contemplated surgery is a left shoulder arthroscopy with subacromial decompression. However, the medical records failed to indicate the presence of cardiovascular or pulmonary comorbidities that may warrant preoperative testing. Furthermore, the present request did not specify what particular laboratory tests were to be done and a discussion regarding the indications for these tests were also not documented. A clear rationale for the request was also not provided. The patient's age was also below 50 years old, which was not recommended by the guidelines. In addition, a progress report dated February 6, 2014 stated that the patient was already 11 days post-operative for left shoulder arthroscopy with subacromial decompression. Therefore, the request for PREOPERATIVE CLEARANCE is not medically necessary.