

<b>Case Number:</b>	CM15-0013375		
<b>Date Assigned:</b>	03/10/2015	<b>Date of Injury:</b>	03/03/2014
<b>Decision Date:</b>	04/09/2015	<b>UR Denial Date:</b>	01/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/23/2015

### 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 50-year-old male who sustained an industrial injury on 03/03/14. Injury occurred when he was shoveling dirt and slipped and fell into the hole. Past medical history was significant for type II diabetes and hypertension. He underwent right shoulder arthroscopic rotator cuff repair, Mumford procedure, subacromial decompression, posterior Bankart labral repair, and chondroplasty of the glenohumeral joint on 7/30/14. The 11/11/14 right shoulder MRI impression documented soft tissue anchors from prior rotator cuff repair, tears of the supraspinatus and infraspinatus tendons, minimal subacromial and subscapularis bursitis, and minimal glenohumeral joint effusion. There was acromioclavicular joint osteoarthritis, biceps tenosynovitis, and a tear of the superior glenoid labrum with paralabral cyst. The 12/08/14 treating provider report cited persistent right shoulder pain, weakness and stiffness. Physical exam documented forward flexion to 100 degrees, abduction to 70 degrees, and external rotation to 50 degrees. There was global rotator cuff weakness. Imaging showed a rotator cuff tear and questionable labral tear, adhesive capsulitis, and tightness of the capsule. Surgery was recommended to include arthroscopic lysis of adhesions, capsular release and repairs of the rotator cuff and labrum as indicated. On 01/20/15, utilization review certified a request for right shoulder arthroscopy, lysis of adhesions, capsular release, manipulation under anesthesia, rotator cuff repair, and possible labral repair with 7 day cold therapy unit rental. The requests for preoperative EKG, laboratory studies, and medical clearance were non-certified as the patient had no evidence of a medical problem requiring specialty medical clearance and pre-operative

EKG and lab studies were no longer considered medically necessary, citing non-MTUS guidelines.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Associated Surgical Service: Cold therapy unit:** 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).

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

**Decision rationale:** The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. The 1/20/15 utilization review recommended partial certification of this cold therapy device for 7-day use. There is no compelling reason in the records reviewed to support the medical necessity of a cold device beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.

**Pre-operative EKG:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for Pre-Anesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Pre-Anesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines state that an 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. Guideline criteria have been met. This injured worker has a past medical history positive for diabetes and hypertension. Additionally, middle-aged males have known occult increased risk factors for cardiovascular disease that support the medical necessity of pre-procedure EKG. Therefore, this request is medically necessary.

**Pre-operative labs:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for this service. Evidence based medical 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. Guideline criteria have not been met. A generic request for non-specific pre-operative lab work is under consideration. Although, basic lab testing would typically be supported for patients undergoing this procedure and general anesthesia, the medical necessity of a non-specific cannot be established. Therefore, this request is not medically necessary.

**Pre-operative medical clearance:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**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) Pre-operative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

**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. Guideline criteria have been met based on the patient's age, comorbidities, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.