

Case Number:	CM15-0188137		
Date Assigned:	09/30/2015	Date of Injury:	02/23/2013
Decision Date:	11/12/2015	UR Denial Date:	09/18/2015
Priority:	Standard	Application Received:	09/24/2015

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, Oregon, Washington
 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 55 year old female, who sustained an industrial-work injury on 2-23-13. A review of the medical records indicates that the injured worker is undergoing treatment for pain in the joint involving the right shoulder and right shoulder rotator cuff syndrome. Treatment to date has included pain medication, right shoulder injection 7-21-14, diagnostics, physical therapy and other modalities. Medical records dated 9-1-15 indicate that the injured worker complains of continued right shoulder pain. Per the treating physician report dated 7-14-15 the injured worker has returned to work with light duties. The physical exam dated 9-1-15 reveals right shoulder exam has positive Neer's and Hawkin's test, tenderness over the bicipital groove, tenderness of the acromioclavicular joint (AC), and rotator cuff strength 4+ out of 5. The physician indicates that the Magnetic Resonance Imaging (MRI) of the right shoulder dated August 2015 reveals a full thickness supraspinatus tendon tear, severe biceps tendinitis and chronic superior labral tear from anterior to posterior (SLAP) tear. The physician recommended surgical intervention. The request for authorization date was 9-1-15 and requested service included Preoperative Labs (unspecified). The original Utilization review dated 9-18-15 non- certified the request for Preoperative Labs (unspecified).

IMR ISSUES, DECISIONS AND RATIONALES

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

Preoperative Labs (unspecified): 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, Preoperative testing general.

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. The request to Independent Medical Review is for a test or treatment which was not adequately defined. The treating physician did not supply sufficient information regarding the nature of the request and its indications. The request is therefore not medically necessary based on the lack of sufficient indications and details of the request provided by the treating physician.