Case Number:	CM15-0197898		
Date Assigned:	10/13/2015	**Date of Injury:**	12/07/2009
Decision Date:	11/20/2015	**UR Denial Date:**	09/04/2015
Priority:	Standard	**Application Received:**	10/08/2015

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: Montana
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 58 year old male, who sustained an industrial injury on December 07, 2009. The injured worker was diagnosed as having status post right shoulder surgeries for rotator cuff repair and left shoulder rotator cuff tear. The medical records noted that the injured worker had a history of diabetes, high blood pressure, liver disease, plantar fasciitis, and reflex esophagitis. Treatment and diagnostic studies to date has included chiropractic therapy, medication regimen, magnetic resonance imaging of the left shoulder, Neurodiagnostic study, and shoulder injection.In a progress note dated April 29, 2015 the treating physician reports of aching pain to the left shoulder that radiates to the left arm and hand along with tingling and weakness to the shoulder and numbness to the left arm and hand. The progress note from April 29, 2015 noted that the injured worker's pain level was rated an 8 out of 10. A review of the systems performed on April 29, 2015 was revealing for chest pains, sleep disturbance, and shortness of breath. Examination reveals from April 29, 2015 was revealing for decreased range of motion to the bilateral shoulders with positive bilateral Hawkin's and Neer's testing. The progress note from April 29, 2015 included magnetic resonance imaging report of the left shoulder performed on December 10, 2014 that was revealing for "subacromial-subdeltoid bursal fluid consistent with distal supraspinatus tendonitis, tear, or a combination of both. Distal supraspinatus mixed signal changes suspicion of distal supraspinatus tendonitis, tear, or combination of both. Tear is likely with distraction gap." The progress note from April 29, 2015 did not indicate any treatment plan for cardiac symptoms, but did request left shoulder arthroscopy for rotator cuff repair. The medical records provided did not include any family

practice evaluations prior to the date of September 04, 2015. On September 02, 2015, the treating physician requested an electrocardiogram pre-operatively. On September 04, 2015, the Utilization Review determined the request for an electrocardiogram (EKG) to be non-approved.

IMR ISSUES, DECISIONS AND RATIONALES

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

EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Preoperative Electrocardiogram (ECG).

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

Decision rationale: The ODG guidelines note that preoperative electrocardiograms (ECG) are recommended for patients undergoing high-risk surgery and that undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Preoperative ECGs in patients without known risk factors for coronary disease, regardless of age, may not be necessary. Preoperative and postoperative resting 12-lead ECGs are not indicated in asymptomatic persons undergoing low-risk surgical procedures. Low risk procedures (with reported cardiac risk generally less than 1%) include endoscopic procedures; superficial procedures; cataract surgery; breast surgery; & ambulatory surgery. An ECG within 30 days of surgery is adequate for those with stable disease in whom a preoperative ECG is indicated. (Fleisher, 2008) (Feely, 2013) (Sousa, 2013) Criteria for Preoperative electrocardiogram (ECG): High Risk Surgical Procedures: These are defined as all vascular surgical procedures (with reported cardiac risk often more than 5%, which is the combined incidence of cardiac death and nonfatal myocardial infarction), and they include: Aortic and other major vascular surgery; & Peripheral vascular surgery. Preoperative ECG is recommended for vascular surgical procedures. Intermediate Risk Surgical Procedures: These are defined as procedures with intermediate risk (with reported cardiac risk generally 1-5%), and they include: Intraperitoneal and intrathoracic surgery; Carotid end arterectomy; Head and neck surgery; & Orthopedic surgery, not including endoscopic procedures or ambulatory surgery. Preoperative ECG is recommended for patients with known CHD, peripheral arterial disease, or cerebrovascular disease. Preoperative ECG may be reasonable in patients with at least 1 clinical risk factor: History of ischemic heart disease; History of compensated or prior HF; History of cerebrovascular disease, diabetes mellitus, or renal insufficiency. Low Risk Surgical Procedures: These are defined as procedures with low risk (with reported cardiac risk generally less than 1%), and they include: Endoscopic procedures; Superficial procedures; Cataract surgery; Breast surgery; & Ambulatory surgery. ECGs are not indicated for low risk procedures. In this case, the injured worker is undergoing low risk surgery (left shoulder arthroscopy for rotator cuff repair) which does not require an electrocardiogram. Although he does have risk factors of diabetes, obesity and hypertension, which might require EKG as part of his routine medical care, the request for EKG is not medically necessary from the preoperative standpoint.