

<b>Case Number:</b>	CM15-0205664		
<b>Date Assigned:</b>	10/22/2015	<b>Date of Injury:</b>	06/23/2014
<b>Decision Date:</b>	12/07/2015	<b>UR Denial Date:</b>	10/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/19/2015

### 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

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 48 year old male who sustained an industrial injury on 06-23-2014. A review of the medical records indicated that the injured worker is undergoing treatment for right shoulder impingement syndrome with rotator cuff tendinopathy. Medical history was not disclosed. According to the treating physician's progress report on 09-10-2015, the injured worker continues to experience right shoulder pain. Examination of the right shoulder demonstrated decreased range of motion with forward flexion at 60 degrees, abduction at 70 degrees and external rotation at 70 degrees with positive Hawkins and Neer's tests. Right shoulder magnetic resonance imaging (MRI) (no date documented) was interpreted within the progress note dated 05-08-2015 which showed "significant supraspinatus tendinopathy with acromioclavicular joint osteoarthropathy". Prior treatments have included diagnostic testing, activity modification, 2 steroid injections in the right shoulder (last dose in 07-2015 into the subacromial space), physical therapy, home exercise program and medications. Current medications were listed as Tramadol ER 100mg, Naproxen and Protonix. The injured worker is temporarily partially disabled (TPD). Treatment plan consists of surgical intervention with arthroscopy subacromial decompression (unknown if authorized) and the current request for pre-operative history and physical examination, Anesthesiologist and Electrocardiogram (EKG). On 10-08-2015 the Utilization Review determined the request for pre-operative history and physical examination, Anesthesiologist and Electrocardiogram (EKG) was not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **1 Electrocardiogram: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Preoperative perioperative pre-operative testing perioperative testing, Perioperative protocol, Health care protocol, National Guideline Clearinghouse (NGC), Rockville MD, Agency for Healthcare Research and Quality (AHRQ).

**Decision rationale:** The MTUS guidelines and ODG do not discuss preoperative testing; therefore, alternative guidelines were consulted. Per the cited guidelines, abnormal findings (noted on the preoperative basic health assessment) are results that require further evaluation to assess and optimize any surgical/anesthesia risk or cares. Further evaluation may be as simple as asking a few more questions, performing further physical examination, or ordering a laboratory or radiological exam. More in-depth evaluations may be needed, such as a consultation or cardiac stress testing. Most laboratory and diagnostic tests (e.g., hemoglobin, potassium, coagulation studies, chest x-rays, electrocardiograms) are not routinely necessary unless a specific indication is present and may be beyond the scope of this protocol. Other abnormal findings, though relevant to the patient's general health, may not have any impact on the planned procedure or the timing of the procedure. Evaluation and management of these incidental findings should follow standard medical practice and are beyond the scope of the protocol. Chest x-ray is recommended if the patient has signs or symptoms suggesting new or unstable cardiopulmonary disease. The following are recommended for preoperative EKG: 1) Perform electrocardiogram for all patients age 65 and over, within one year prior to procedure, 2) Electrocardiograms are not indicated, regardless of age, for those patients having cataract surgery, 3) Preoperative electrocardiograms are not recommended for patients undergoing other minimal risk procedures, unless medical history/assessment indicate high-risk patient. These guidelines recommend that patients should be identified perioperatively if they are an active carrier or have history of MDRO, such as MRSA, but laboratory screening without significant history is not supported by these guidelines. The injured worker is not reported to have significant history to support perioperative testing. Additionally, there is no evidence in the available documentation that the requested subacromial decompression has been authorized. The request for 1 electrocardiogram is determined to not be medically necessary.

## **1 Pre-operative History and Physical examination: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Preoperative perioperative pre-operative testing perioperative testing, Perioperative protocol, Health care protocol, National Guideline Clearinghouse (NGC), Rockville MD, Agency for Healthcare Research and Quality (AHRQ).

**Decision rationale:** The MTUS guidelines and ODG do not discuss preoperative testing; therefore, alternative guidelines were consulted. Per the cited guidelines, a pre-operative physical examination is supported prior to surgery and abnormal findings are results that require further evaluation to assess and optimize any surgical/anesthesia risk or cares. Further evaluation may be as simple as asking a few more questions, performing further physical examination, or ordering a laboratory or radiological exam. More in-depth evaluations may be needed, such as a consultation or cardiac stress testing. Most laboratory and diagnostic tests (e.g., hemoglobin, potassium, coagulation studies, chest x-rays, electrocardiograms) are not routinely necessary unless a specific indication is present and may be beyond the scope of this protocol. Other abnormal findings, though relevant to the patient's general health, may not have any impact on the planned procedure or the timing of the procedure. Evaluation and management of these incidental findings should follow standard medical practice and are beyond the scope of the protocol. Chest x-ray is recommended if the patient has signs or symptoms suggesting new or unstable cardiopulmonary disease. The following are recommended for preoperative EKG: 1) Perform electrocardiogram for all patients age 65 and over, within one year prior to procedure, 2) Electrocardiograms are not indicated, regardless of age, for those patients having cataract surgery, 3) Preoperative electrocardiograms are not recommended for patients undergoing other minimal risk procedures, unless medical history/assessment indicate high-risk patient. These guidelines recommend that patients should be identified perioperatively if they are an active carrier or have history of MDRO, such as MRSA, but laboratory screening without significant history is not supported by these guidelines. In this case, there is no evidence in the available documentation that the requested subacromial decompression has been authorized. The request for 1 Pre-operative history and physical examination is determined to not be medically necessary.

**1 Anesthesiologist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Preoperative perioperative pre-operative testing perioperative testing, Perioperative protocol, Health care protocol, National Guideline Clearinghouse (NGC), Rockville MD, Agency for Healthcare Research and Quality (AHRQ).

**Decision rationale:** The MTUS guidelines and ODG do not discuss preoperative testing; therefore, alternative guidelines were consulted. Per the cited guidelines, a pre-operative physical examination is supported prior to surgery and abnormal findings are results that require further evaluation to assess and optimize any surgical/anesthesia risk or cares. Further evaluation may be as simple as asking a few more questions, performing further physical examination, or ordering a laboratory or radiological exam. More in-depth evaluations may be needed, such as a consultation or cardiac stress testing. Most laboratory and diagnostic tests (e.g., hemoglobin, potassium, coagulation studies, chest x-rays, electrocardiograms) are not routinely necessary unless a specific indication is present and may be beyond the scope of this protocol. Other abnormal findings, though relevant to the patient's general health, may not have any impact on the planned procedure or the timing of the procedure. Evaluation and

management of these incidental findings should follow standard medical practice and are beyond the scope of the protocol. Chest x-ray is recommended if the patient has signs or symptoms suggesting new or unstable cardiopulmonary disease. The following are recommended for preoperative EKG: 1) Perform electrocardiogram for all patients age 65 and over, within one year prior to procedure, 2) Electrocardiograms are not indicated, regardless of age, for those patients having cataract surgery, 3) Preoperative electrocardiograms are not recommended for patients undergoing other minimal risk procedures, unless medical history/assessment indicate high-risk patient. These guidelines recommend that patients should be identified perioperatively if they are an active carrier or have history of MDRO, such as MRSA, but laboratory screening without significant history is not supported by these guidelines. In this case, there is no evidence in the available documentation that the requested subacromial decompression has been authorized. The request for 1 Anesthesiologist is determined to not be medically necessary.