

Case Number:	CM15-0011167		
Date Assigned:	01/29/2015	Date of Injury:	03/01/1999
Decision Date:	03/26/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/21/2015

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: Orthopedic Surgery, Sports 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 43-year-old female who reported an injury on 03/01/1999. The mechanism of injury was not provided. The injured worker was noted to be approved for surgical intervention for a rotator cuff surgery. Prior surgeries were noted to include bilateral carpal tunnel syndrome surgery, right elbow surgery for epicondylitis and tenosynovitis, right middle and thumb trigger finger release in 2005, left middle finger trigger release in 2006, three steroid injections into the left shoulder, and 1 steroid injection in the right shoulder. The medications included Dexilant 60 mg 1 tablet, trazodone 100 mg tablets, and Topamax 25 mg at bedtime. The injured worker's medical history included hypercholesterolemia, history of peptic ulcer disease, hypothyroidism, and migraine headaches. The diagnoses included possible SLAP lesion tear, left shoulder impingement syndrome with mild adhesive capsulitis, and left shoulder partial tear of the rotator cuff.

IMR ISSUES, DECISIONS AND RATIONALES

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

associated surgical service: Pre op medical clearance and labs; CBC, PT, PTT, Lytes, BUN, UA, Chem 7: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery.

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, Society of General Internal Medicine Guidelines.

Decision rationale: Per the Society of General Internal Medicine Online, “Preoperative assessment is expected before all surgical procedures”. The clinical documentation submitted for review indicated the injured worker had been approved for surgical intervention; as such a preoperative clearance would be supported. The Official Disability Guidelines indicate that preoperative urinalysis is recommended for injured workers undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing is performed on injured workers who have underlying chronic disease and those taking medications that may predispose them to electrolyte abnormalities or renal failure. A complete blood count is indicated for injured workers with disease that increase the risk of anemia or injured workers in whom significant perioperative blood loss is anticipated and coagulation studies are reserved for injured workers with a history of bleeding or medical conditions that predispose them to bleeding and for those taking anticoagulants. The clinical documentation submitted for review failed to provide documented rationale for the requested interventions. Additionally, as this portion of the request would not be supported, the request in its entirety must be denied. Given the above, the request for associated surgical services and labs: CBC, PTP, PTT, lytes, BUN, UA, chem. 7 is not medically necessary.

associated surgical service: Chest X-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery

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.

Decision rationale: The Official Disability Guidelines indicate that chest radiography is reasonable for injured workers at risk for postoperative pulmonary complications if the results would change perioperative management. The clinical documentation submitted for review indicated the injured worker had previously undergone surgical interventions. There was a lack of documentation indicating a necessity for an associated chest x-ray. Given the above, the request for associated surgical service chest x-ray is not medically necessary.

associated surgical service: EKG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery

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 electrocardiogram (ECG).

Decision rationale: The Official Disability Guidelines indicate an EKG is recommended for injured workers who have symptoms of active cardiovascular disease. It is not necessary for low risk surgeries or ambulatory surgeries. The clinical documentation submitted for review failed to provide the rationale for the requested intervention. Given the above, the request for associated surgical service: EKG is not medically necessary.

associated surgical service: Cold Therapy Unit purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder Chapter; Postoperative pain pump

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

Decision rationale: The Official Disability Guidelines indicate that continuous flow cryotherapy is recommended for 7 days postoperatively. The injured worker was approved for surgical intervention. However, there was a lack of documentation indicating a necessary for purchase versus rental. Given the above, the request for associated surgical service: cold therapy unit purchase is not medically necessary.