

<b>Case Number:</b>	CM15-0117554		
<b>Date Assigned:</b>	06/25/2015	<b>Date of Injury:</b>	02/12/2014
<b>Decision Date:</b>	07/24/2015	<b>UR Denial Date:</b>	05/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/17/2015

### 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, Indiana, New York  
Certification(s)/Specialty: Internal 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 30 year old female, who sustained an industrial injury on 2/12/2014. Diagnoses have included failure of right total hip arthroplasty. Treatment to date has included physical therapy and medication. The injured worker underwent right total hip arthroplasty on 10/8/2014. According to the progress report dated 5/11/2015, the injured worker complained of difficulties with her prosthetic hip. She had made an attempt to return to dance which was unsuccessful. She reported lack of flexibility, specifically hip flexion, and problems with both strength and pain after activity. During passive range of motion of the hip, there was a palpable grind and audible squeak, which was worse compared to prior exams. The treatment plan was for surgical revision of the right hip. Authorization was requested for pre-operative labs.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pre-op Labs:** 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), Low back, Preoperative lab testing.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.aafp.org/afp/2013/0315/p414.html>.

**Decision rationale:** Pursuant to the American Family Physician, preoperative labs are not medically necessary. Pre-operative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. 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. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. In this case, the injured worker's working diagnoses are failure of right ceramic on ceramic total hip arthroplasty secondary to squeaking. According to a May 11, 2015 progress note the injured worker failed the total hip arthroplasty and is scheduled for a revision. The treatment plan does not discuss or document or provide a clinical indication or rationale for preoperative lab testing and EKGs. Additionally, the documentation does not provide the specific laboratory testing to be ordered. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. There is no documentation of underlying chronic disease. Consequently, absent clinical documentation with the clinical rationale for ordering preoperative lab testing and the specific details regarding specific laboratory testing, preoperative labs are not medically necessary.