

<b>Case Number:</b>	CM15-0128846		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	10/03/1996
<b>Decision Date:</b>	08/10/2015	<b>UR Denial Date:</b>	06/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2015

### 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, Oregon  
 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 46 year old female who sustained an industrial /work injury on 10/3/96. She reported an initial complaint of right shoulder pain. The injured worker was diagnosed as having right shoulder rotator cuff impingement with partial rotator cuff tear and AC (acromioclavicular) joint arthrosis. Treatment to date includes medication, diagnostics, chiropractic treatment, and transcutaneous electrical nerve stimulation (TENS) unit. MRI results were reported on 2/11/15 and revealed a small articular surface tear in the supraspinatus tendon just proximal to its attachment to the greater tuberosity of the humerus and a distal clavicular bone bruise. Currently, the injured worker complained of right shoulder pain located in the lateral deltoid area and over the AC joint, associated with popping and clicking. Per the primary physician's report (PR-2) on 6/8/15, exam notes tenderness at the AC joint, range of motion is 180/90/80, pain and weakness with abduction and external rotation testing, and impingement sign is positive. Current plan of care included surgery to right shoulder. The requested treatments include pre-operative medical clearance/CBC (complete blood count), CMP (complete metabolic profile).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pre-operative medical clearance/CBC, CMP: 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).

**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.

**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. 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. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 46 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore the request is not medically necessary.