Case Number:	CM14-0043455		
Date Assigned:	07/02/2014	**Date of Injury:**	02/01/2012
Decision Date:	08/28/2014	**UR Denial Date:**	02/20/2014
Priority:	Standard	**Application Received:**	03/27/2014

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. The expert reviewer is Board Certified in Internal Medicine, Pulmonary Diseases and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 45-year-old female who reported an injury on 02/01/2012, with the mechanism of injury not cited within the documentation provided. In the clinical notes dated 02/13/2014, the injured worker complained of left wrist pain. It was noted that the injured worker complained that there was numbness and tingling into all digits of the left hand. Prior treatments included physical therapy, acupuncture, immobilization and activity modification and prescribed pain medications. The physical examination of the left hand and wrist revealed a positive Phalen's test, a negative Tinel's and Durkan's and no tenderness to palpation over the first, fourth, or sixth extensor compartments. It was noted radiocarpal range of motion was full with flexion, extension, pronation, supination, radial and ulnar deviation. Specialized stability testing demonstrated negative ulnar grind, negative Watson's. The diagnoses included bilateral wrist De Quervain's tenosynovitis, bilateral elbow lateral epicondylitis, EMG based diagnosis of bilateral carpal tunnel syndrome and right hand thumb trigger finger. The treatment plan included a request for left wrist carpal tunnel surgical intervention with preoperative workup.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRE-OP MEDICAL CLEARANCE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation THE AMERICAN ACADEMY OF

ORTHOPEDIC SUGEONS CHAPTER 9 PERIOPERATIVE MEDICAL MANAGEMENT, PAGE 105-113.

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 Complaints, Preoperative testing, general.

Decision rationale: The Official Disability Guidelines (ODG) state that preoperative testing (e.g. test radiography, electrocardiography, laboratory testing, and urinalysis) is often performed for surgical procedures. These investigations can be helpful to stratify risks, 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. Injured workers with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Injured workers undergoing low risk surgery do not require electrocardiography. Routine preoperative tests are defined as those done in the absence of any specific clinical indication or purpose and typically include a panel blood test, urine test, chest radiography and electrocardiogram. These tests are performed to find underlying abnormalities such as anemia or silent heart disease that could impact how, when, or whether the planned surgical procedure and concomitant anesthesia are performed. It is unclear whether the benefits occurred from response to true positive tests outweigh the harms of false positive preoperative tests and, if there is a net benefit, how this benefit compares to the resource utilization required for testing. An alternative to routine preoperative testing for the purpose of determining fitness for anesthesia identify injured workers at high risk of postoperative complications may be to conduct a history and physical examination, with selected testing based on the clinician's findings. In the clinical notes provided for review, there is lack of documentation of the injured worker having a history of any cardiovascular disease or postoperative pulmonary complications. There is also a lack of documentation of the surgery being authorized. Therefore, the request for pre-operative medical clearance is not medically necessary and appropriate.