

Case Number:	CM14-0207787		
Date Assigned:	12/19/2014	Date of Injury:	08/25/2004
Decision Date:	02/10/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	12/11/2014

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 Plastic Surgery and is licensed to practice in Maryland. 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 patient is a 54-year old female with a reported date of injury on 8/25/04 who requested pre-op laboratory studies (CBC, Metabolic Chem) and EKG. She had signs and symptoms of right ring finger triggering with plans for operative release. The requesting physician stated that 'standard anesthesia guidelines require CBC, metabolic chem and EKG for patients over 50 years old to have surgery.' From the medical records provided an orthopedic history is documented, but no other specific medical history including medication lists were documented. UR dated 11/17/14 did not certify the testing stating that there was a lack of documentation of comorbidities to support pre-op labs and EKG.

IMR ISSUES, DECISIONS AND RATIONALES

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

ASSOCIATED SURGICAL SERVICES: Pre-op Labs (CBC, Metabolic Chem) and EKG:
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), Treatment Index, 11th Edition (web), 2014, Low Back, Preoperative Testing, General

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 Pain, Preoperative lab testing, Preoperative electrocardiogram (ECG). Other Medical Treatment

Guideline or Medical Evidence: ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery.

Decision rationale: Based on review of the medical documentation, there is insufficient justification for routine preoperative laboratory testing. No specific medical condition was noted in the documentation to warrant general laboratory testing. From ODG, Preoperative additional tests are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. (Feely, 2013) (Sousa, 2013) Criteria for Preoperative lab testing: - 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. Thus, as recommended by ODG, the decision to order preoperative laboratory testing should be guided by the patient's clinical history, comorbidities and physical examination findings. There has not been sufficient medical documentation to warrant this. The patient is not sufficiently documented to have a chronic disease, taking medications that would pre-dispose the patient to electrolyte abnormalities, or that there would be an expectation of significant blood loss from the procedure. Thus, without specific detail as to the reasoning for ordering preoperative testing, this should not be considered medically necessary. With respect to an EKG, from ODG, Preoperative electrocardiogram (ECG): 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. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Preoperative ECGs in patients without known risk factors for coronary disease, regardless of age, may not be necessary. Preoperative and postoperative resting 12-lead ECGs are not indicated in asymptomatic persons undergoing low-risk surgical procedures. Low risk procedures (with reported cardiac risk generally less than 1%) include endoscopic procedures; superficial procedures; cataract surgery; breast surgery; & ambulatory surgery. An ECG within 30 days of surgery is adequate for those with stable disease in whom a preoperative ECG is indicated. (Fleisher, 2008) (Feely, 2013) (Sousa, 2013). Based on the medical records reviewed, there is not sufficient evidence to warrant ECG. The patient is undergoing a low-risk procedure of a trigger finger release and has not been documented to have risk factors or symptoms. Further from ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Non-cardiac Surgery: Preoperative and postoperative resting 12-lead

ECGs are not indicated in asymptomatic persons undergoing low-risk surgical procedures. Thus, based on the medical records provided, ECG should not be considered medically necessary.