Case Number:	CM14-0208848		
Date Assigned:	12/22/2014	**Date of Injury:**	04/01/2013
Decision Date:	05/01/2015	**UR Denial Date:**	12/04/2014
Priority:	Standard	**Application Received:**	12/12/2014

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. 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: Maryland, Virginia, North Carolina
Certification(s)/Specialty: Plastic 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 male who sustained an industrial injury on 4/1/2013. His diagnoses, and/or impressions, include complex lacerations of the right volar middle and index fingers; injury digital nerve; carpal tunnel syndrome; tenosynovitis finger; and upper extremity neuropathy. His treatments have included irrigation and debridement, with exploration of wounds, with suturing of deep lacerations to the right volar middle and index fingers at the time of the accident, followed by surgery to his right middle and index fingers later that same day; electromyogram and nerve conduction studies; post-operative physical therapy; work restrictions; and medication management. The physician's report of 7/14/2014, note the development of intermittent right middle and index finger pain, when making a fist, which radiates up the arm and into the shoulder, and is associated with numbness and tingling; surgery was recommended. The physician's treatment requests included chest x-ray, electrocardiogram, pre-operative laboratories, and pre-operative medical clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: Chest X-Ray: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low back pain, preoperative testing, general.

Decision rationale: The patient is a 46 year old male who was certified for right index finger common digital nerve repair. The patient is not noted to be taking any medications and is without any major illnesses. There is insufficient documentation/justification for a CXR. The medical history does not provide detail that the patient would be at risk of pulmonary complications or that the patient has a medical condition that would require evaluation with a CXR. The planned surgical procedure should be considered low risk in an ambulatory patient. Thus, without further clarification related to the reason for ordering the CXR, this should not be considered medically necessary. ODG, preoperative testing, general: Preoperative 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.

Associated Surgical Service: Pre-Operative Laboratory Work: Complete Blood Count (CBC), Chemistry 7, Prothrombin Time (PT), Partial Thromboplastin Time (PTT): 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 9web), 2014, Low Back, preoperative lab testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back pain, preoperative lab testing.

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 general laboratory testing. 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.

Associated Surgical Service: Electrocardiogram (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 electrocardiogram (ECG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, preoperative electrocardiogram(ECG)ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac Surgery.

Decision rationale: The patient is a 46 year old male who is undergoing a relatively low-risk hand surgical procedure. There is minimal documentation that the patient has any medical comorbidities. He is not documented to have any major illnesses or is taking medications. 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 and has no evidence of clinical significant medical illness. Further from ACC/AHA 2007 Guidelines on Perioperative Cardiovascular Evaluation and Care for Noncardiac 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.

Associated Surgical Service: Pre-Op Medical Clearance: Overturned

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, Forearm, Wrist & Hand and nerve repair surgery.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low back pain, preoperative testing, general.

Decision rationale: The patient is a 46 year old male who was certified for a microsurgical hand procedure. The medical history documented does not support that an abundance of preoperative testing is necessary. However, as from ODG guidelines and as general anesthesia will likely be performed, a preoperative medical clearance is consistent with ODG, preoperative testing as follows: An alternative to routine preoperative testing for the purpose of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings. Thus, preoperative medical clearance should be considered medically necessary.