

Case Number:	CM15-0007312		
Date Assigned:	01/26/2015	Date of Injury:	06/28/2011
Decision Date:	03/17/2015	UR Denial Date:	01/07/2015
Priority:	Standard	Application Received:	01/13/2015

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 47 year old female, who sustained an industrial injury on 06/28/2011. On provider visit dated 10/09/2014, the injured worker has reported Kenalog injection did not help, pain and throbbing in right thumb, occasional locking of right thumb and stiffness and decreased range of motion of the right thumb. The diagnoses have included status post blunt trauma to right hand, status post development of right trigger thumb, status post right thumb A1 pulley release, and right thumb neuroma formation radial digital nerve. On 01/07/2015 Utilization Review non-certified Pre-Operative H& P (history and physical). The ODG were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Preoperative H&P: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Preoperative testing, general

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/23547574>
<http://www.uptodate.com/contents/evaluation-of-cardiac-risk-prior-to-noncardiac-surgery>

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and Up-to-Date, preoperative history and physical examination is not medically necessary. Thorough history taking is always important in clinical assessment and treatment planning for the patient with chronic pain and includes a review of the medical records. Clinical recovery may be dependent on identifying and addressing previously unknown or undocumented medical and psychosocial issues. A thorough physical examination is important to establish/confirm diagnoses and observe/understand pain behavior. The history and physical examination also serves to establish reassurance and patient confidence. 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. 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. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. Patients in their usual state of health who are undergoing cataract surgery do not require preoperative testing. In this case, the injured worker's working diagnoses are status post blunt trauma to the right hand; status post development right trigger thumb; s/p right thumb A-1 pulley release (3/8/12); right thumb neuroma formation radial digital nerve. The surgical procedure was a neuroma excision. A low-risk surgery does not require a medical clearance by a second physician when the treating physician is obligated to perform a detailed history and physical examination upon accepting the patient. This injured worker was having a neuroma excision (according to the record). The treating physician, through a detailed history and physical examination, may determine if the injured worker was at risk for any other call morbid conditions. The treating physician could have determined if there was a risk of cardiac or pulmonary issues. The medical documentation does not reflect any comorbid cardiac, pulmonary or renal issues. Consequently, absent clinical documentation to support a consultation to a second physician for a history and physical examination, a preoperative history and physical examination for a new Roma excision is not medically necessary.