

Case Number:	CM14-0103993		
Date Assigned:	09/16/2014	Date of Injury:	09/20/2013
Decision Date:	05/06/2015	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/07/2014

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 38 year old male, who sustained an industrial injury on September 20, 2013. He reported pain and bleeding in the left middle finger. Diagnoses include 2 lacerations, nail avulsion, and crushing injury of the left middle finger. The initial treatment included emergent irrigation and suturing of the lacerations of the left middle finger followed by dressing changes. He developed necrosis and exposed bone at the tip left middle finger in November 2013. On January 3, 2014, he underwent a partial tip amputation of the left middle finger. On August 8, 2014, he underwent a revision of the left middle finger amputation. Other treatment to date has included x-rays, work modifications, occupational/physical therapy, and medications including antibiotics, pain, muscle relaxant, and non-steroidal anti-inflammatory. In the occupational therapy progress note from September 17, 2014, the injured worker complains of continued middle finger sensitivity at the lateral aspects of the revision scar site and numbness or tingling at the left middle finger. The physical exam revealed normal range of motion of the metacarpophalangeal and proximal interphalangeal joints, amputation at the distal phalanx, decreased left grip/pinch strength, and slight hypersensitivity at the ulnar/radial aspects of the amputation sites. The treatment plan includes continuing therapy. The requested treatments are pre-op medical clearance with electrocardiogram (EKG)/CBC with history and physical done in office, chest x-ray, and post-op occupational therapy for the left hand.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chest x-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OKU 9, chapter 9, Perioperative Medical Management, table 1 the considerations for laboratories.

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 38 year old male who was certified for left long finger revision amputation. The patient had requested EKG/CBC/preoperative medical clearance/CXR and history and physical. EKG, CBC and history/physical was certified. There is minimal supporting documentation that the patient would need a CXR prior to a left long finger revision amputation. 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 for 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. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. Therefore, as there is not sufficient documentation that the patient is at risk of postoperative pulmonary complication or has a medical history that warrants a work-up to include a CXR, this request is not medically necessary. If, on history and physical examination, there is some concern for a pulmonary issue, this could be reconsidered.

Preoperative medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopedic Surgeons, Orthopedic Knowledge Update, OKU 9, 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 Low back pain, preoperative testing, general.

Decision rationale: The patient is a 38 year old male who was certified for left long finger revision amputation. The patient had requested EKG/CBC/preoperative medical clearance/CXR and history and physical. EKG, CBC and history/physical was certified. The medical history

documented does not support that an abundance of preoperative testing is necessary. From ODG guidelines and as general anesthesia will likely be performed preoperative testing is addressed 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, as the patient was certified for a history and physical examination, this request is not medically necessary.