

<b>Case Number:</b>	CM15-0114195		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	09/12/2014
<b>Decision Date:</b>	07/28/2015	<b>UR Denial Date:</b>	06/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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: Oregon

Certification(s)/Specialty: Plastic Surgery, Hand 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:

This 20 year old male sustained a crush injury to the right hand on 9/12/14. The injured worker underwent revision amputation of the index finger at the level of the P1IP joint, repair of the extensor mechanism of the long finger, open reduction internal fixation proximal phalanx of the long finger and repair of complex laceration of long and ring finger on 9/12/14. The injured worker received postoperative hand therapy and medications. In an orthopedic evaluation dated 4/30/15, the injured worker complained of ongoing difficulty with pinching and gripping activities and limited range of motion of the long finger. The injured worker had not worked since his injury. Physical exam was remarkable for the index finger amputated at the proximal phalanx level. The injured worker could flex well at the metacarpophalangeal joint. The long finger had limited range of motion. Sensation was present on the radial and ulnar aspects of the right finger. Current diagnoses included crush injury to right hand and joint contractures. The physician recommended right long finger extensor tenolysis with pip joint release, preoperative laboratory studies and postoperative hand therapy and custom orthosis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Preop labs: CBC & CMP:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement, Preoperative evaluation, Bloomington (MN).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Back.

**Decision rationale:** ODG-TWC, Low Back updated 5/15/15 states: "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 preoperative management. Patients in their usual state of health who are undergoing cataract surgery do not require preoperative testing. (Feely, 2013) Routine preoperative tests are defined as those done in the absence of any specific clinical indication or purpose and typically include a panel of blood tests, urine tests, chest radiography, and an electrocardiogram (ECG). These tests are performed to find latent 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 accrued from responses 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 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. However, the relative effect on patient and surgical outcomes, as well as resource utilization, of these two approaches is unknown. (AHRQ, 2013) The latest AHRQ comparative effectiveness research on the benefits and harms of routine preoperative testing, concludes that, except for cataract surgery, there is insufficient evidence comparing routine and per-protocol testing." There is insufficient evidence to support routine preoperative testing for low risk procedures, and in this case, the records do not document any medical issues that require selective preoperative testing.

**12 post op hand therapy sessions:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 20.

**Decision rationale:** Per MTUS: Extensor tendon repair or tenolysis [DWC]: Postsurgical treatment: 18 visits over 4 months Postsurgical physical medicine treatment period: 6 months. The request for 12 visits is consistent with the guidelines.

**1 custom orthosis:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist & Hand (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

**Decision rationale:** Per ACOEM: Restriction of activity or immobilization should be employed only for short periods of time because both result in deconditioning and bone loss in a matter of days. Bone or muscle lost in this way cannot be restored without undertaking a reconditioning program. In addition, aching, stiffness, and pain will occur if muscles and joints are not used. As pain decreases, mobilization of painful areas can proceed carefully. Depending on the condition, in question, aerobic and specific activities may improve comfort both acutely and as recovery progresses. ACOEM allows splinting depending on the condition in question. In this case, splinting is a standard part of finger joint contracture release.