

Case Number:	CM15-0178440		
Date Assigned:	09/16/2015	Date of Injury:	10/07/2014
Decision Date:	10/23/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	09/10/2015

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: 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 64-year-old female with an industrial injury dated 10-07-2014. Review of the medical records indicates she is being treated for right carpal tunnel syndrome (with electro diagnostic confirmation). Medical history is documented as hypertension. Surgical history is documented as left wrist surgical fixation with subsequent plate removal and right shoulder rotator cuff repair. In the progress note dated 07-27-2015, the treating physician documented the injured worker had developed "carpal tunnel symptoms shortly after her fall, which have become progressive in spite of greater than 10 sessions of therapy, night splinting, anti-inflammatories and cortisone injection by report." She presented on 07-27-2015 with complaints of nocturnal paresthesia that awaken her from sleep as well as paresthesia that interfere with her activities of daily living. She reports that her paresthesia is only in the median nerve distribution. Her medications included Fenoprofen, Tartrate and Flexeril. Physical examination is documented as showing positive Tinel, positive Phalen and positive compression with no thumb abductor atrophy. The treating physician documents she has "failed all non-operative treatment." Prior treatments are documented as physical therapy (at least 18 sessions), splinting, anti-inflammatories and cortisone injection. The treatment plan was for right carpal tunnel release, comprehensive history and physical, hand therapy, Relafen and Percocet. The request for authorization dated 08-12-2015 is for pre-operative comprehensive history and physical. On 08-20-2015 the request for pre-operative comprehensive history and physical was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-operative comprehensive history and physical: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, State of California Official Medical Fee Schedule, 1999 Edition, Pages 92-93.

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 testing, general.

Decision rationale: The patient is a 64-year-old female with a history of hypertension who was certified for a right carpal tunnel release. Based on the entirety of the medical record, the patient has a history of hypertension and should be evaluated fully prior to any surgical intervention. Therefore, a preoperative history and physical examination should be considered medical necessary to evaluate this and to stratify the patient's risk and determine if further medical testing is necessary. From ODG guidelines and as general anesthesia is likely to be performed, preoperative testing should be as follows: An alternative to routine preoperative testing for the purposes 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, a history and physical should be considered medically necessary. The UR had stated that this should be included as part of the overall surgical plan. However, the requesting surgeon may not have the expertise to determine suitability for surgery. Therefore, this should be provided by a physician who is capable.