

Case Number:	CM13-0010004		
Date Assigned:	12/27/2013	Date of Injury:	09/01/2011
Decision Date:	02/11/2014	UR Denial Date:	07/26/2013
Priority:	Standard	Application Received:	08/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Plastic and Reconstructive Surgery and is licensed to practice in Maryland. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 55 year old right hand dominant female with a reported work-related date of injury on 9/1/11 who requested treatment for osteoarthritis of the right thumb with a suspensionplasty and postoperative occupational therapy. She is documented to be a clerical worker. She has a history of bilateral thumb pain, documented to have CMC arthritis bilaterally with the left sided pain worse than the right. Pain has developed over 2 years with left side greater than right. Examination documents bilateral grind test positive and tenderness at the CMC joint. Previous therapy included NSAIDs, avoidance behavior and steroid injection (only documented on the left side). Previous progress note dated 3/29/13 notes history of bilateral thumb pain that is worsened with typing. Right thumb pain had been stable as noted from 2/15/13 and treated with NSAIDs while left thumb CMC joint was treated with steroid injection previously. X-rays of both thumbs are stated to show CMC arthritis. The treatment discussed included avoidance behavior, NSAIDs, followed by steroid injection. If this fails then surgery is considered. At that time, recommendation was made for surgical treatment of the left thumb CMC arthritis, which is stated to have been denied although later certified. Due to failure of conservative management the patient underwent left thumb suspensionplasty including trapeziectomy and APL tendon insertion on 5/9/13. Progress note dated 6/19/13 notes s/p 6 weeks from left suspensionplasty and the thumb is feeling better. No documentation of the right thumb is noted. Progress note from 7/17/13 notes reason for appointment 'WC left thumb pain'. The patient is 2.5 months following left suspensionplasty and attending hand therapy. Examination of the right thumb is not noted. Assessment is CMC arthritis and plan for surgery and wear splint as necessary, presumably on the right side although not specifically stated. The utilization review dated 7/26/13 state

IMR ISSUES, DECISIONS AND RATIONALES

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

Right thumb suspensionplasty surgery: 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), 2013, Forearm, Wrist & Hand Chapter, Trapeziectomy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist, hand, Trapeziectomy and the Management of Thumb Carpometacarpal Joint Arthritis Article.

Decision rationale: From the California MTUS guidelines, ACOEM p. 270, general surgical principles are discussed. 'Surgical considerations depend on the confirmed diagnosis of the presenting hand or wrist complaint. If there is no clear indication for surgery, referring the patient to a physical medicine practitioner may aid in formulating a treatment plan. The patient is well documented to have had a need for left sided intervention, as she had failed reasonable non-operative management. However, following the left-sided surgery there is minimal to no documentation with respect to the progression on the right side. The surgeon documented that after failure of medical management and avoidance behavior, steroid injection would be the next step. In the medical records reviewed, I only see evidence that the left side had been injected. In addition, I do not see clear specific documentation that the patient has maintained right thumb splinting. The last review of the right side had said that the pain was stable but that the left side was the more symptomatic side. The patient is stated to have had x-rays showing right sided CMC arthritis but no formal x-ray report was provided in the medical review. The overall documentation is not sufficient to show that conservative management has failed. From the ODG, trapeziectomy is recommended among the different surgeries used to treat persistent pain and dysfunction at the base of the thumb from osteoarthritis, trapeziectomy is safer and has fewer complications than the other procedures. Participants who underwent trapeziectomy had 16% fewer adverse effects than the other commonly used procedures studied in this review; conversely, those who underwent trapeziectomy with ligament reconstruction and tendon interposition had 11% more (including scar tenderness, tendon adhesion or rupture, sensory change, or Complex Regional Pain Syndrome Type 1). (Wajon, 2005) (Field, 2007) (Raven, 2006) Persistent pain and dysfunction as not been adequately defined in the most recent documentation following the left sided surgery to provide clear indications for surgery. As documented in the above article, "Not all patients with arthritis of the thumb carpometacarpal joint will require surgery. There are some patients with visible deformities and marked radiographic changes who are symptom free and require no treatment. The first step in relieving a symptomatic patient is adequate patient education regarding the cause of the pain and behavior modification to minimize pain production. Nonsteroidal anti-inflammatory medication can be added should the pain persist. If this is not enough to alleviate the symptoms, a custom-made short opponens splint can be fabricated to stabilize the carpometacarpal joint while still allowing the interphalangeal and/or the metacarpophalangeal joint to move. Finally, should splinting and

nonsteroidal anti-inflammatory drugs prove ineffective in eliminating the pain; a steroid can be injected into the carpom

Post-op occupational therapy three times a week for four weeks: 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), 2013, Forearm, Wrist & Hand Chapter, Trapeziectomy.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.