

Case Number:	CM14-0051259		
Date Assigned:	06/23/2014	Date of Injury:	05/26/2010
Decision Date:	07/18/2014	UR Denial Date:	03/17/2014
Priority:	Standard	Application Received:	03/21/2014

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. The expert reviewer is Board Certified in Plastic and Reconstructive Surgery and is licensed to practice in Maryland, Virginia and North Carolina. 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/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 68 year old male with a reported date of injury on 5/26/10 who requested flexor tendon transfer to the left thumb. Previous surgery of the left upper extremity included surgical treatment on 12/14/12 for left CMC (carpo-metacarpal) arthritis, left thumb tendon interposition arthroplasty with trapezium excision and full thickness flexor carpi radialis. On 4/3/12 the patient was noted to have undergone left carpal tunnel release and left ulnar neuroplasty with in-situ decompression. Documentation from 9/20/13 notes the patient with complaint of left hand pain and severe left thumb weakness. He had returned to work, but was then placed back on disability due to clinical status. Examination documents left-sided 'severe atrophy of the thenar eminence' and sensation intact to light touch. Electrodiagnostic studies were ordered. Documentation from 10/4/13 notes continued weakness in thumb opposition and referral for surgical consideration. Previous electrodiagnostic studies from 2/29/12 document bilateral median neuropathy at the wrist. Electrodiagnostic studies from 10/8/13 note 'There is still evidence of median sensory neuropathy bilaterally. Some of this latency can be due demyelinating neuropathy.' EMG report notes increased insertional activity and moderately increased spontaneous activity of the Left Abductor Pollicis Brevis muscle. A request was made on 11/5/13 for left median nerve neurolysis at the wrist. Examination noted severe atrophy of the left thenar eminence and thumb opponens strength is severely limited. Recommendation was made for re-exploration of the median nerve at the left wrist. The patient was then referred to a hand specialist. Documentation from this physician on 11/21/13 notes patient has a lack of thumb opposition. Examination notes this lack of opposition as well as 'no sensation in the median nerve distribution' and 'marked atrophy of his thenar muscles.' Recommendation was made for thumb opposition transfer from the ring finger flexor tendon sublimis. Utilization review dated 1/27/14 did not certify the initial request for tendon transfer from the ring finger to

the thumb in order to restore opposition. Reasoning stated was 'there is no guideline support, as well as there is lacking indication the patient has complied with any conservative treatment beyond the formal therapy from the from the first tendon transfer or work with modified duty.' In response to this denial, documentation from 2/13/14 notes that the patient has chronic pain and left opponen's weakness and thenar atrophy. He has been off work because of this and previously had been treated with a home exercise program and physical therapy. He had been referred to the requesting surgeon due to his condition. Examination documents 'opponens weakness 2/5 and left thumb severe thenar atrophy.' Recommendation was made for tendon transfer. Documentation from 2/26/14 and 3/12/14 notes continued left hand pain, lack of thumb opposition and continued recommendation for tendon transfer. Further follow-up notes recommendation for exercise therapy and continued recommendation for tendon transfer. Utilization review dated 3/17/14 did not certify the procedure. Reasoning given was that the patient had previously undergone a tendon transfer from the flexor carpi radialis in December of 2012 and recovered following physical therapy with return to work with regained strength and no pain. However, the patient had return of weakness, but no additional formal therapy is noted following this change in the patient's condition. 'Proceeding with an additional surgery to aid in thumb opposition when there is no guideline support, as well as there is lacking indication the patient has continued with any conservative treatment beyond the formal therapy from the first tendon transfer, or worked with modified duty, is not indicated.' In addition previous request for tendon transfer was not certified from 1/27/14. Response from the denial of the utilization review by the requesting surgeon dated 5/8/14 notes the patient has lack of thumb opposition and has failed conservative measures. He states that his recommendation is for an opponens transfer with use of the flexor digitorum sublimis transfer of the ring finger (not the small finger).

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective request for 1 surgery of the left thumb.: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-268-269.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Scott W. Wolfe, Robert N. Hotchkiss, William C. Pederson, and Scott H. Kozin, Green's Operative Hand Surgery , Sixth Edition, 2011. Chapter 34, 1093-1137.

Decision rationale: The patient is a 68 year old male who is well-documented to have severe thumb weakness in opposition, as well as severe muscle atrophy of the thenar eminence. He is noted to have undergone previous surgeries to include carpal tunnel release and treatment of CMC arthritis using a full thickness flexor carpi radialis. He had undergone formal physical therapy following his surgery with initial improvement and return to work. However, he began to have severe weakness and atrophy of his thumb intrinsics affecting his ability to work. He was then placed out of work as he couldn't perform his usual duties. He is documented to have undergone a home exercise program. Electrodiagnostic studies confirmed muscle change of the thumb consistent with his exam findings. The patient was referred to a hand specialist who

recommended flexor tendon transfer from the ring finger to the thumb. This was non-certified twice, due to failure of formal conservative measures, as well as there is no guideline support for the proposed surgery. Overall, by the review of the entirety of the medical record the patient has demonstrated failure of non-surgical treatment. He is specifically documented to have undergone a home exercise program, as well as modification of his work environment as he was placed on total temporary disability. The ACOEM and ODG does not specifically address the proposed surgery. However, from page 270 of ACOEM reasons for surgical intervention consultation are listed: Referral for hand surgery consultation may be indicated for patients who:- Have red flags of a serious nature- Fail to respond to conservative management, including worksite modifications- Have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. The patient clearly has satisfied these 3 requirements. Severe weakness, lack of thumb opposition and severe thenar atrophy are red flags of a serious nature. He has failed conservative management as documented above. His worksite modifications is to not to return to work, as he is unable to perform appropriate duties. In addition, opponensplasty using the flexor digitorum sublimis(or superficialis) is well described to treat this condition, as discussed in Green's Operative Hand Surgery Chapter 34 pages 1093-1137:Four Standard OpponensplastiesThere are four widely used, reliable opponensplasties, at least one of which will be appropriate for the vast majority of clinical situations:1 Flexor digitorum superficialis (FDS) opponensplasty: Royle-Thompson technique or Bunnell technique. 2 EIP opponensplasty. 3 Huber transfer (ADM). 4 Camitz procedure (palmaris longus)Superficialis Opponensplasties. There is no universally accepted "best" technique of superficialis transfer, and a wide variety of harvesting techniques, pulley constructions, and transfer insertions are used. The ring finger superficialis is widely used as the opponensplasty motor. However, because this may weaken power grip, some surgeons prefer to use the middle finger superficialis if this is available. Potential transfer insertions were discussed earlier in this chapter. In summary, the rationale for non-certification is adequately addressed by the requesting surgeon and by review of the medical record. The patient has undergone non-operative therapy (although not specifically recent formal physical therapy) including worksite modification and a home exercise program. This has failed to result in improvement. Given the severity of the findings and confirmatory electrodiagnostic studies, formal physical therapy would not be expected to provide improvement. In addition, the surgery requested by the physician is well-documented as discussed above and thus provides guideline support. The medical record directly addresses the assertion in the utilization review that worksite modifications had not been made. The patient returned to work, but was then placed out-of-work due to his condition. In addition, as documented by the requesting surgeon, the actual proposed surgery is from the ring finger superficialis (described in Green's Operative Hand Surgery) and not the small finger as documented in the utilization review. Thus, flexor tendon transfer from the ring finger to the thumb is medically necessary.