

Case Number:	CM14-0056342		
Date Assigned:	07/09/2014	Date of Injury:	11/22/2010
Decision Date:	08/08/2014	UR Denial Date:	04/21/2014
Priority:	Standard	Application Received:	04/25/2014

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 54-year-old female with a report date of injury on 11/22/10, who complains of left thumb and hand pain. Documentation from 4/4/14 notes that the patient has undergone "extensive conservative treatment including splinting, topical anti-inflammatories, stellate ganglion blocks, injections under fluoroscopy, physical therapy and neurology referrals." This has not improved her condition. The patient is stated to have basilar thumb arthritis and complex regional pain syndrome. Recommendation is made for basilar thumb arthroplasty, Interposition arthroplasty, and Ligament reconstruction. Documentation from 2/24/14 notes similar findings as the notes from 4/4/14. Documentation from Neurology dated 12/10/13, notes that the patient had undergone a previous left stellate ganglion block that did not help her. She has had a cortisone injection under fluoroscopy to the left basilar thumb, without relief. Medication treatment has included Norco, Vicodin, gabapentin and Lidoderm patches, without improvement. She is currently taking an anti-inflammatory medication and Norco and treats her left hand pain with ice periodically. An examination notes tenderness along the left thumb with decreased range of motion. The diagnoses reported include complex regional pain syndrome, left basilar thumb arthropathy and secondary DeQuervain's on the left forearm. Recommendation was made for a triphasic nuclear bone scan, repeat left stellate ganglion block and Lyrica. If these interventions fail to improve the patient, a recommendation was made to consider surgery for basilar thumb arthroplasty. A request for authorization was made for stellate ganglion block, bone scan, and Lyrica on the same day. Documentation from Agreed Medical Examination dated 11/14/13, notes that the patient has undergone splinting, physical therapy, lidoderm patches and topical analgesics for treatment of the left hand. Cortisone injection of the left thumb was performed on 9/25/13 that did not help. A previous recommendation was made for left thumb surgery, but had been recommended to see Neurology prior to surgery. She

complains of frequent numbness in her left hand and forearm. An examination notes pain of the left thumb. The left wrist is tender along the carpometacarpal (CMC) joint. X-rays of the left thumb are reported to show mild to moderate degenerative changes with slight progression as compared to 11/4/11. An MRI report of the left hand and wrist from 5/20/11, are stated to be read as normal. A neurology consultation and possible psychiatric consultation was recommended prior to the thumb arthroplasty. DeQuervain's tenosynovitis is considered as an additional diagnosis as well as left wrist symptomatic osteoarthritis of the first CMC joint. Documentation from the requesting surgeon dated 11/12/13, notes a diagnosis of left basilar thumb arthritis and complex regional pain syndrome. Many different conservative measures have been attempted. She had little relief from a cortisone injection to the left thumb. He recommended basilar thumb arthroplasty, but recommended a neurology consultation prior to this. The medical records state, "I told her I would guess the success rate would be somewhere in the region of a 50-50 chance of improving her pain". "I believe the neurologist will help confirm the diagnosis of complex regional pain syndrome and may offer some other intervention that may negate the need for the procedure or may make the chances of it being successful in getting rid of her pain more of a possibility". The utilization review dated 4/21/14 indicated that the left basilar thumb interposition arthroplasty and ligament reconstruction was not certified. The reasoning provided was that "a comprehensive physical examination of the left thumb was not provided for review. Also, there is no summary of diagnostics done to date for the left hand".

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Basilar Thumb Interposition Arthroplasty: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment For Worker's Compensation, Online Edition, Chapter: Forearm, Wrist And Hand, Arthroplasty, finger and/or thumb (joint replacement).

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 and Hand, Trapeziectomy; and Cook, Geoffrey S. M.D.; Lalonde, Donald H. M.D., MOC-PS(SM) CME Article: Management of Thumb Carpometacarpal Joint Arthritis, Plastic & Reconstructive Surgery: January 2008 - Volume 121 - Issue 1S - pp 1-9.

Decision rationale: The MTUS/ACOEM Guidelines indicate "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". From the medical records provided for this review, the treating surgeon has not adequately defined the left thumb carpometacarpal (CMC) arthritis. It is documented that the patient has left thumb pain around the CMC joint and has undergone conservative management. However, as stated by the utilization reviewer, there is not a recent comprehensive, left thumb examination and documentation of significant osteoarthritis of the

CMC joint. The last x-ray was only a stated report and from the Agreed Medical Examination dated 11/14/13. In addition, the patient was only stated to have mild to moderate osteoarthritis. A previous MRI examination noted a normal exam, from 5/20/11. No formal x-ray or MRI reports were provided in this medical review. In addition, the patient has a complicated medical presentation given the diagnosis of Complex Regional Pain Syndrome. Recommendation was made for evaluation and treatment by Neurology. An initial evaluation was provided, but no follow-up to this evaluation had been provided. An additional stellate ganglion block was recommended, as well as a bone scan and Lyrica. The specific success or failure of these measures from the Neurologist was not provided. In addition, recommendation from the Agreed Medical examination noted a possible psychiatry evaluation. This has not been addressed as well. The patient may in fact need surgical intervention, but the overall documentation is not sufficient to confirm that the patient would be improved with surgery. An adequate x-ray report and examination of the left thumb to support the diagnosis of significant osteoarthritis of the CMC joint is not provided. In addition, adequate follow-up of the recommended treatments has not been provided. The requesting surgeon also states that he is 50/50 that the surgery may help. The Official Disability Guidelines indicate that a trapeziectomy is recommended among the different surgeries used to treat persistent pain and dysfunction at the base of the thumb from osteoarthritis, and that 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). The requested procedures are also not consistent with the guideline recommendation. As documented in the above article from Cook et al, 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. A non-steroidal 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 non-steroidal anti-inflammatory drugs prove ineffective in eliminating the pain, a steroid can be injected into the carpometacarpal joint. The patient does have evidence that she has failed non-operative management and may benefit from surgery. But, as discussed above, there is insufficient documentation of the degree of severity of the condition support by the radiographic studies. Follow-up of recommended treatment has not been provided. Therefore, the request is not medically necessary.

Ligament Reconstruction: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
http://www.wheelsonline.com/ortho/ligament_reconstruction_and_tendon_interposition.

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 and Hand, Trapeziectomy; and Cook, Geoffrey S. M.D.; Lalonde, Donald H. M.D., MOC-PS(SM) CME Article: Management of Thumb Carpometacarpal Joint Arthritis, Plastic & Reconstructive Surgery: January 2008 - Volume 121 - Issue 1S - pp 1-9.

Decision rationale: The MTUS/ACOEM Guidelines indicate "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". From the medical records provided for this review, the treating surgeon has not adequately defined the left thumb carpometacarpal (CMC) arthritis. It is documented that the patient has left thumb pain around the CMC joint and has undergone conservative management. However, as stated by the utilization reviewer, there is not a recent comprehensive, left thumb examination and documentation of significant osteoarthritis of the CMC joint. The last x-ray was only a stated report and from the Agreed Medical Examination dated 11/14/13. In addition, the patient was only stated to have mild to moderate osteoarthritis. A previous MRI examination noted a normal exam, from 5/20/11. No formal x-ray or MRI reports were provided in this medical review. In addition, the patient has a complicated medical presentation given the diagnosis of Complex Regional Pain Syndrome. Recommendation was made for evaluation and treatment by Neurology. An initial evaluation was provided, but no follow-up to this evaluation had been provided. An additional stellate ganglion block was recommended, as well as a bone scan and Lyrica. The specific success or failure of these measures from the Neurologist was not provided. In addition, recommendation from the Agreed Medical examination noted a possible psychiatry evaluation. This has not been addressed as well. The patient may in fact need surgical intervention, but the overall documentation is not sufficient to confirm that the patient would be improved with surgery. An adequate x-ray report and examination of the left thumb to support the diagnosis of significant osteoarthritis of the CMC joint is not provided. In addition, adequate follow-up of the recommended treatments has not been provided. The requesting surgeon also states that he is 50/50 that the surgery may help. The Official Disability Guidelines indicate that a trapeziectomy is recommended among the different surgeries used to treat persistent pain and dysfunction at the base of the thumb from osteoarthritis, and that 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). The requested procedures are also not consistent with the guideline recommendation. As documented in the above article from Cook et al, 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. A non-steroidal 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 non-steroidal anti-inflammatory drugs prove ineffective in eliminating the pain, a steroid can be injected into the carpometacarpal joint. The

patient does have evidence that she has failed non-operative management and may benefit from surgery. There is insufficient documentation of the degree of severity of the condition support by the radiographic studies. Follow-up of recommended treatment has not been provided. Therefore, the request is not medically necessary.