Case Number:	CM14-0090888		
Date Assigned:	07/25/2014	**Date of Injury:**	09/18/2013
Decision Date:	03/04/2015	**UR Denial Date:**	06/09/2014
Priority:	Standard	**Application Received:**	06/16/2014

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. 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:

This is a 61 year old female who suffered an olecranon fracture on 9/18/13 and underwent an open reduction internal fixation of the left olecranon fracture and cubital tunnel release. Following the surgery she complained of hand, elbow and shoulder pain and also complains of stiffness of the left hand. She has received physical therapy, is taking narcotic pain medication and received steroid injections in the shoulder. She also uses a brace with elastic bands to provide passive extension to her fingers. Her diagnoses were olecranon fracture and complex regional pain syndrome. (MRI) magnetic resonance imaging of the left hand performed on 5/2/14 was read as normal and (MRI) magnetic resonance imaging of the left wrist performed on the same day revealed tear of the membranous portion of left scapholunate ligament, tear of the membranous portion of the left lunotriquetral ligament, 1 mm tear in the radial attachment of left triangular fibrocartilage and mild osteoarthritis of left basal joint with degenerative changes of the left pisotriquetral joint. (MRI) magnetic resonance imaging of the left shoulder 2/4/14 revealed extensive tendonitis of the supraspinatus, degenerative joint disease and hypertrophic A.C. joint changes and possible intrasubstance rotator cuff tear of the supra spinatus tendon. On 5/7/14 x-ray of the left shoulder revealed decreased bone mineralization and a lucency which was likely a vascular channel. On 5/20/14 and again on 5/30/14 the injured worker continued to complain of persistent stiffness in the left hand especially the MCP joints of the index, long, ring and little fingers with minimal active flexion. Joint manipulation under anesthesia of the left index, long, ring and little fingers followed by use of Chins strap and aggressive joint mobilization and tendon gliding exercises was the recommended treatment plan. The treatment

plan for PR2 dated 5/27/14 was to continue modified work, hold physical therapy for the current time and follow up with sports medicine clinic. The treatment plan on the most recent progress report dated 6/4/14 was for arthroscopic debridement of posterior elbow, hardware removal from elbow and manipulation under anesthesia of the shoulder with a cortisone injection. On 6/9/14 Utilization Review non-certified MCPJ manipulation under anesthesia of left long, index, ring and little fingers, citing there were no subjective or objective findings or complaints of metacarophalangeal joint it appears it is a typographical error and MTUS recommendations for hand surgery. Previous ROM of the left fingers from 12/11/13 noted flexion limit at 5 cm from the palm. Previous recommendations had been made for aggressive hand therapy. Documentation from February 11, 2014 noted improvement in the left hand exam was improving. Documentation from 2/26/14 noted pulp to palm at 1.5 with soft end points. Continued hand therapy was recommended. Therapy documentation from 3/6/14 did not address the hand. Documentation from 4/8/14 noted pulp to palm at 2 cm. End points are soft and passively correctable. She would benefit from aggressive hand therapy. Documentation from an initial consultation dated 4/22/14 notes recommendation for an aggressive hand therapy regimen including aggressive joint mobilization, tendon gliding and strengthening. Hand therapy documentation was provided for service on 5/20/14 with plans for dynamic/static progressive splinting.

IMR ISSUES, DECISIONS AND RATIONALES

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

Metacarpophalangeal joint manipulation under anesthesia of the left long finger, index finger, ring finger and little finger: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270.

Decision rationale: The patient is a 61 year old female with a previous olecranon fracture who complained of stiffness of the left hand. She is reported to have undergone physical therapy. She had been documented to have lack of flexion of the left fingers due to stiffness. She had been recommended for aggressive hand therapy on a second opinion and later hand therapy documentation notes plans for dynamic/static progressive splinting. In addition, the patient is being considered for shoulder surgery. Overall, based on the medical records provided, the patient has poor range of motion of the left hand/fingers. However, there does not appear to be enough time for full use of conservative management as recommended from the physician performing the second opinion (who is the requesting surgeon). There had not been adequate documentation of the physical therapy performed based on the recommendation from 4/22/14. The only documentation from physical therapy was a one-time visit, providing instruction of dynamic/static progressive splinting. If this fails to provide functional improvement, then consideration for manipulation under anesthesia could be reconsidered and later consideration for more specific surgical treatment.