

Case Number:	CM15-0186121		
Date Assigned:	09/28/2015	Date of Injury:	06/03/2015
Decision Date:	11/03/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	09/21/2015

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: California, Oregon, Washington
 Certification(s)/Specialty: Orthopedic 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 21-year-old male sustained an industrial injury on 6-3-15. Documentation indicated that the injured worker was receiving treatment for a right third finger laceration. On 6-16-15, the injured worker underwent right 3rd finger exploration of wound, repair of ulnar digital nerve, micro-dissection of radial digital nerve and repair of flexor digitorum profundus tendon. The injured worker received postoperative physical therapy, splinting and medications. In a physical therapy progress note dated 7-7-15, physical exam was remarkable for moderate edema and tenderness to palpation to the right 3rd finger, right wrist range of motion: extension 41 degrees, flexion 80 degrees, radial deviation 20 degrees, ulnar deviation 7 degrees, radial abduction 50 degrees, 3rd finger metacarpophalangeal joint 0 to 54 degrees, proximal interphalangeal joint 17 to 26 degrees and distal interphalangeal joint 17 to 28 degrees. In a physical therapy progress note dated 8-7-15, physical exam was remarkable for right 3rd finger with edema and tenderness to palpation at the distal interphalangeal joint fusion, a well-healed palmar scar and range of motion: right wrist extension 49 degrees, flexion 80 degrees, radial deviation 20 degrees, ulnar deviation 30 degrees and 3rd finger metacarpophalangeal joint 0 to 82 degrees, proximal interphalangeal joint 0 to 95 degrees and distal interphalangeal joint 0 to 55 degrees. On 8-25-15, a request for authorization was submitted for flexor tenolysis of the FDP tendons of the right third finger with open capsulotomy of the PIP joint, ulnar digital nerve neurolysis with possible neuroplasty and postoperative physical therapy. On 9-9-15, Utilization Review noncertified a request for flexor tenolysis of the FDP tendons of the right third finger with open capsulotomy of the PIP joint, ulnar digital nerve neurolysis with possible neuroplasty and postoperative physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexor tenolysis of the FDP tendons of the right third finger with open capsulotomy of the PIP joint, ulnar digital nerve neurolysis with possible neuroplasty: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand Chapter, Flexor tendon repair, Early mobilization after flexor tendon repair.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic) / tenolysis.

Decision rationale: Per ODG: recommended as indicated below. Flexor tenolysis is a surgical procedure used to remove adhesions that inhibit active flexion of digits. Tenolysis is useful to improve function of tendons bound in scar tissue when the indications and techniques are carefully followed. Tenolysis is unsuccessful when done in the face of poor indications, when the tendon is not freed completely, or when the tenolysis is performed in association with complex orthopaedic procedures which do not permit early postoperative active motion. Flexor tenolysis is a challenging procedure with valuable clinical usefulness in the restitution and enhancement of digital function in the appropriate patient. In the absence of complications, improvement in digital flexion can be expected. The requisites for success are a skilled surgeon, a motivated and well informed patient, and a closely monitored hand therapy program. Normal active tendon function requires that flexor tendons be able to glide smoothly within their tendon sheath. Damage to these tendons can require surgical repair, and in spite of successful surgical tendon repair, tendon adhesions can develop during the healing process, when scar tissue develops that connects tendons to the surrounding tendon sheath, thereby impeding normal tendon function. Patients present with decreased active range of motion following surgical repair of flexor tendons. The average time from flexor repair to flexor tenolysis is around 8 months but ranges from 2 to almost 25 months. Tenosynovectomy may be done in conjunction with tenolysis when there is inflammation of the lining of the tendon sheath (tenosynovitis). During a tenosynovectomy, the inflamed material around the affected tendon is carefully removed. (Wheless, 2012) (Azari, 2005) (Tolat, 1996) (Fetrow, 1967) See also Carpal tunnel release surgery (CTR). Criteria for Flexor tenolysis: Patient must be willing to commit to a rigorous course of physical therapy (vigorous postoperative ROM is required); Patient must have good strength in flexor and extensor muscles of the hand and must have intact nerves to flexor muscles; If patient has had previous flexor tendon repair, surgery should be delayed until 6 months post op (in order to avoid tendon rupture), otherwise at least 3 months conservative treatment (PT); Consider using a wrist block and propofol anesthesia, so that the patient can demonstrate active motion in the operating room (indicating whether the tenolysis has been successful); If tenolysis does not achieve sufficient ROM, repeated tenolysis is not indicated; Contraindicated in patients with active infection, motor-tendon problems secondary to denervation, and unstable underlying fractures requiring fixation and immobilization. Relative contraindications include extensive adhesions, immature previous scars, and severe posttraumatic underlining arthrosis. In this case the patient had operative repair on 6/16/15. It has not been over 6 months since surgery and thus the patient does not meet ODG criteria for tenolysis. The recommendation is not medically necessary.

12 post operative therapy sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.