Case Number:	CM15-0204859		
Date Assigned:	10/21/2015	**Date of Injury:**	10/04/2014
Decision Date:	12/03/2015	**UR Denial Date:**	10/07/2015
Priority:	Standard	**Application Received:**	10/19/2015

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: 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:

The injured worker is a 47 year old male, who sustained an industrial-work injury on 10-4-14. He reported initial complaints of right ring finger pain. The injured worker was diagnosed as having contracture to the right hand with an acquired deformity to the right finger. Treatment to date has included medication, occupational therapy (failed), pinning and casting, and diagnostics. MRI results were reported on 3-17-15 notes rupture of the pulley at the proximal interphalangeal joint of the fourth finger with displacement of the superficial flexor and deep flexor tendon. Currently, the injured worker complains of flexion contracture and deformity to right ring finger. Work is with modified duty. Per the primary physician's progress report (PR-2) on 9-25-15, exam notes a flexion contracture with deformity at 100 degrees at the proximal interphalangeal joint. Current plan of care includes surgery. The Request for Authorization requested service to include Z-plasty of skin contracture, volar and dorsal right ring finger proximal interphalangeal joint release, possible flexor tendon tenolysis, possible hinged ex fix, possible volar plate reconstruction with Palmaris longus tendon graft and post-operative physical therapy, 24 visits. The Utilization Review on 10-7-15 denied the request for Z-plasty of skin contracture, volar and dorsal right ring finger proximal interphalangeal joint release, possible flexor tendon tenolysis, possible hinged ex fix, possible volar plate reconstruction with Palmaris longus tendon graft and post-operative physical therapy, 24 visits., per Official Disability Guidelines (ODG), Forearm, Wrist and Hand Chapter and CA MTUS (California Medical Treatment Utilization Schedule) Guidelines: Post-surgical treatment 2009. Documentation from 5/20/15 noted that the right ring finger had a contracture at 90 degrees. A second opinion was recommended prior to a fusion.

Documentation from 6/12/15 noted that the plan was for range-of-motion, JAS and occupational therapy. He had been placed on modified duty. Documentation from 6/17/15 noted that the patient had received a second opinion with recommendation for aggressive occupational therapy and JAS splinting. The patient's hand function is affected by his current flexion contracture. If therapy failed, consideration would be given for tendon reconstruction. Documentation 7/21/15 noted that options were discussed with the patient included do nothing, aggressive hand therapy followed by surgical intervention to repeat release and slowly straighten the finger or fusion of the finger. Further follow-up noted no significant improvement from conservative management. The scarring had softened and would be amenable to surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

Z-plasty of skin contracture, volar and dorsal right ring finger proximal interphalangeal joint release, possible flexor tendon tenolysis, possible hinged ex fix, possible volar plate reconstruction with Palmaris longus tendon graft: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand Chapter.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Book Chapter. The Stiff Finger. Alexander Y. Shin and Peter C. Amadio. Green's Operative Hand Surgery, chapter 11, 355-388.

Decision rationale: The patient is a 47 year old male who had suffered previous right ring finger injury. He was noted to have a right ring finger flexion contracture and underwent attempted surgical release and pinning of the right ring finger on 4/9/15. Of note, the patient's finger was not able to be successfully straightened. The flexor tendons appeared to be bowstringing without a rupture of the pulley. A fusion was considered a possibility as well as a second opinion. The patient had undergone a second opinion that initially recommended aggressive conservative management with hand therapy, JAS splinting and activity modification. This was performed without any meaningful improvement. He had significant loss of function due to a severe, flexion contracture. Surgical options included attempted complex surgical reconstruction versus fusion. To improve range of motion and ultimately hand function, complex surgical reconstruction was recommended. From Chapter 11, page 270, ACOEM, 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. From Green's textbook, "When conservative measures fail to improve a flexion contracture of the PIP joint and the joint remains functionally inadequate, surgical intervention may be indicated. If there are volar skin contractures, Z-plasties or excision of scar tissue and coverage with vascularized skin flaps such as a cross-finger flap should be considered. Any flexor tendon pathology should also be addressed." However, although there are many causes of flexion contractures, the main problem is typically the volar plate and its proximal check rein

expansions. The patient has a severe right ring finger flexion deformity that is adversely affecting function and has failed appropriate conservative management including physical therapy, splinting and activity modification. The requested procedures are consistent with attempted correction of a flexion deformity and therefore should be considered medically necessary. This is consistent with ACOEM and the provided reference. The UR stated that there was not post-procedural imaging, no clear clinical assessment of the tendon or clear clinical evidence of conservative care since the previous operation. Based on the overall clinical scenario, repeat imaging would not be indicated (plain radiographs had been documented to show no bony abnormality). The patient had been well-documented and clearly documented to have undergone appropriate conservative management including physical therapy and splinting. The patient's clinical examination noted a clear, severe, fixed flexion contracture. Thus, the concerns of the UR have been addressed. Therefore the request is medically necessary.

Post-operative physical therapy, 24 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Forearm, Wrist, & Hand.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Forearm, Wrist, & Hand.

Decision rationale: As the procedure was considered medically necessary, physical therapy would be necessary based on the following guidelines: Flexor tendon repair or tenolysis Zone 2 and other than Zone 2 [DWC]: Postsurgical treatment: Flexor tendon repair or tenolysis Zone 2: 30 visits over 6 months. Postsurgical physical medicine treatment period: 8 months. PIP and MCP capsulotomy/capsulectomy [DWC]: Postsurgical treatment: 24 visits over 2 months. Postsurgical physical medicine treatment period: 4 months. From page 10, Initial course of therapy means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d) (1) of this section. Therefore, based on the above guidelines and using the greatest number of visits allowed (30), 24 visits would exceed the initial course of therapy guidelines and should not be considered medically necessary. Up to 12 visits would be consistent with these guidelines for initial treatment.