

Case Number:	CM15-0173665		
Date Assigned:	09/15/2015	Date of Injury:	01/23/2014
Decision Date:	10/16/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	09/03/2015

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 48 year old male who sustained an industrial injury on 1-23-14 resulting in a laceration to the left 5th finger, near complete amputation through the metacarpophalangeal joint. Diagnoses include status post small left finger saw injury through metacarpophalangeal joint; pseudoarthrosis of the metacarpophalangeal joint; Dupuytren's disease (not significantly contributing to his flexion deformity per 7-23-15 note). He currently (7-23-15) is bothered functionally by the chronic metacarpophalangeal flexion (pseudoarthrosis of metacarpophalangeal joint). He denies pain but notes limitation of function with flexed posture of the finger. On physical exam of the left hand there was edema, ecchymosis, open wound plus puckering of skin, tenderness on palpation over the palm, palpable palmer fibromatosis. Diagnostics include x-ray of the left hand (1-23-14) showing fracture-dislocation of the 5th metacarpophalangeal joint. Treatments to date include left small finger metacarpophalangeal joint arthrodesis, extensor digitorum communis repair, zone 5, extensor digiti minimi repair, zone 5, repair of ulnar intrinsic musculature, repair of ulnar digital artery and digital nerve to the small finger, closure of traumatic laceration; hand occupational therapy for active and passive range of motion of the hand, wrist and fingers. The request for authorization dated 7-30-15 indicated left small finger joint silicone replacement arthroplasty soft tissue rearrangement; unknown post-operative hand occupational therapy sessions. In the 7-23-15 progress note the treating provider's plan of care included requests for left small finger joint silicone replacement versus pyrocarbon arthroplasty soft tissue rearrangement to assist in correction of flexion. On 8-7-15 utilization review evaluated and non-certified the requests for left small finger joint silicone

replacement arthroplasty soft tissue rearrangement; unknown post-operative hand occupational therapy sessions based on prior non-certification of the same requests on 4-8-15 and 4-21-15. There were no subjective complaints of pain or any new information to change the prior non-certification decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left small finger joints silicone replacement arthroplasty soft tissue rearrangement:
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 (Acute Chronic): Prosthetic joint replacement.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. 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. Book Chapter, Arthroplasty Procedures in the Hand, Erika Davis Sears and Kevin C Chung, Hand And Upper Extremity Reconstruction, chapter 12, 163-181.

Decision rationale: The patient is a 48 year old male who had previously undergone traumatic injury to his left small finger. The MCP joint of the small finger was not salvageable at the time of the injury and thus, an arthrodesis was performed. Post-operatively, the patient was noted to have significant flexion at the MCP joint, greater than the expected 60 degree from the arthrodesis. At that time, consideration was given for osteotomy and reattempt at arthrodesis. It does not appear that this had been performed as the patient was lost to follow-up. He presented nine months later with poor hand function and a small finger with significant flexion deformity, mainly at the MCP level. He also showed evidence of Dupuytren's contracture, which initially was felt to be contributing to his flexion deformity. He was noted to have a small finger MCP pseudo-arthrosis on fluoroscopy. Consideration was made for arthrodesis versus arthroplasty. As the patient wanted to preserve as much motion as possible, arthroplasty was requested. Initially, this had not been certified. On appeal, the requesting surgeon noted that the patient had adequate bone stock and that Dupuytren's was not providing a significant component to the overall functional deficit. With respect to the indications for arthroplasty, the patient was noted to have no remaining joint surface and that with time this would likely lead to pain and fusion of the MCP joint in an unfavorable condition. In addition, the patient satisfies necessary criteria as he has adequate bone stock and intact extensor tendons. Finally, there were no contraindications as well (lack of stability, nonreconstructible extensor tendons, chronic infection, or lack of patient compliance). From Green's Operative Hand Surgery, with respect to MCP joint arthroplasty: 'Indications for joint arthroplasty of the fingers include an incongruent joint with pain, deformity, or stiffness.' 'It is important to understand that arthrodesis is almost always the major alternative to arthroplasty and should be considered in lieu of arthroplasty in all cases in which the bone stock is poor or the supporting soft tissue is severely damaged or significantly unbalanced.' From the second reference, 'The MCP joints of the fingers should not be fused, unless arthroplasty is technically not possible. Finger motion is initiated at the MCP joint first,

and fusion of the MCP joint will cause great functional impairment by limiting the ability of the fingers to curl around objects.' Based on these references and the medical documentation provided for this review, the patient has a significant post-traumatic deformity of the MCP joint that has failed previous conservative management, is adversely affecting his function, and could likely benefit from MCP arthroplasty. As stated by the requesting surgeon, the patient no longer has joint surfaces due to the original injury and attempted arthrodesis at the time of the injury. The MCP joint was not salvageable at the time. The requesting surgeon has appropriately considered both arthrodesis and arthroplasty. Given the specifics of the case, including an analysis of the peer-reviewed literature, MCP arthroplasty is indicated. As stated above, the MCP joint of the finger should not be fused, unless arthroplasty is technically not possible. The surgeon has supplied enough documentation that an arthroplasty is possible. The above references were provided as ACOEM does not adequately address joint arthroplasty. The UR quoted the ODG guidelines which state for finger joint replacement that an indication is symptomatic arthritis of the proximal interphalangeal joint with preservation of the collateral ligaments. However, the request is for the MCP joint, which as reasoned above, should not be fused unless an arthroplasty is not feasible. The surgeon has provided adequate documentation that this is feasible. The patient has adequate bone stock, the joint is stable and there are intact extensor tendons. The fact that the patient does not have pain or arthritis should not preclude this patient from an attempt at preservation of critical finger motion. The injury was severe, but essentially isolated to the MCP joint area. There was not significant PIP joint involvement with the initial injury and Dupuytren's does not appear to be significantly contributing to the lack of function. Therefore, MCP joint arthroplasty is medically necessary.

Associated surgical services: Unknown post-op hand occupational therapy sessions:
Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

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

Decision rationale: As MCP joint arthroplasty was considered medically necessary, postoperative physical therapy should be considered medically necessary. However, the specific number of visits was not documented and thus is not medically necessary. The guidelines state: Arthropathy, unspecified (ICD9 716.9): Postsurgical treatment, arthroplasty/fusion, wrist/finger: 24 visits over 8 weeks; Postsurgical physical medicine treatment period: 4 months.