

Case Number:	CM15-0179790		
Date Assigned:	09/21/2015	Date of Injury:	09/12/2014
Decision Date:	10/23/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	09/11/2015

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, Indiana, Oregon
 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:

The injured worker is a 55 year old male, who sustained an industrial injury on September 12, 2014. He reported laceration and inability to flex the right small finger after cutting the digit with a box cutter. The injured worker was diagnosed as having marked flexion contracture of the right small finger, post repair of flexor tendon, digital nerve injury of the right small finger and right small finger pulley rupture. Treatment to date has included diagnostic studies, surgical intervention of the right small finger, physical therapy, medications and work restrictions. Currently, the injured worker continues to report continued pain, stiffness, weakness and occasional numbness of the right small finger. The injured worker reported an industrial injury in 2014, resulting in the above noted pain. He was without complete resolution of the pain. Evaluation on May 12, 2015, revealed continued pain as noted. The physician opined that the injured worker had met maximum medical improvement and permanent restrictions should be placed. The physician also noted he did not recommend any significant complex surgical intervention. Evaluation on July 30, 2015, revealed continued pain as noted. It was noted he had not worked since September 12, 2014. It was noted he had a healed incision on the right small finger and a palpable mild bowstring with finger flexion. Additional surgical intervention and post-op occupational therapy were recommended. The RFA included requests for Outpatient right small finger proximal interphalangeal joint and distal interphalangeal joint release, flexor tenolysis, possible hunter rod insertion, and possible pulley reconstruction with tendon autograft, Post-op occupational therapy 3 times a week for 4 weeks for the right small finger, Pre-Op lab:

CBC, CMP, EKG, PT and PTT and was non-certified on the utilization review (UR) on August 31, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient right small finger proximal interphalangeal joint and distal interphalangeal joint release, flexor tenolysis, possible hunter rod insertion, and possible pulley reconstruction with tendon autograft: Overturned

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 (Acute & Chronic) National Institutes of Health.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) hand and Other Medical Treatment Guidelines Dy, Christopher J., and Aaron Daluiski. "Flexor pulley reconstruction." *Hand clinics* 29.2 (2013): 235-242. Stanbury, Spencer J., et al. "The effect of pulley reconstruction on maximum flexion, bowstringing, and gliding coefficient in the setting of zone II repair of FDS and FDP: a cadaveric investigation." *Hand* 9.1 (2014): 99-104.

Decision rationale: CA MTUS/ACOEM is silent on the indication for flexor tenolysis. ODG hand is referenced. The indication for flexor tenolysis is to restore function in a digit with limited motion from flexor tendon adhesions. The patient must be 6 months from flexor tendon repair and not require immobilization for a concomitant pathology. Repeat tenolysis is not indicated if one surgery fails to achieve increase in range of motion. In this case, there are limiting contractures, bowstringing from incompetent pulleys and evidence of failure of non-surgical treatment. Based on the reference guidelines, the request is medically necessary.

Pre-op lab: EKG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back.

Decision rationale: CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states, these investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Preoperative ECG in patients without known risk factor

for coronary artery disease, regardless of age, may not be necessary. CBC is recommended for surgeries with large anticipated blood loss. Creatinine is recommended for patient with renal failure. Electrocardiography is recommended for patients undergoing high risk surgery and those undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 55 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore the request is not medically necessary.

Pre-op lab: CBC: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back.

Decision rationale: CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states, these investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Preoperative ECG in patients without known risk factor for coronary artery disease, regardless of age, may not be necessary. CBC is recommended for surgeries with large anticipated blood loss. Creatinine is recommended for patient with renal failure. Electrocardiography is recommended for patients undergoing high risk surgery and those undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 55 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore the request is not medically necessary.

Pre-op lab: CMP: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back.

Decision rationale: CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states, these investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Preoperative ECG in patients without known risk factor for coronary artery disease, regardless of age, may not be necessary. CBC is recommended for surgeries with large anticipated blood loss. Creatinine is recommended for patient with renal failure. Electrocardiography is recommended for patients undergoing high risk surgery and those undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 55 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore the request is not medically necessary.

Pre-op lab: PT, and PTT: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back.

Decision rationale: CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states, these investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Preoperative ECG in patients without known risk factor for coronary artery disease, regardless of age, may not be necessary. CBC is recommended for surgeries with large anticipated blood loss. Creatinine is recommended for patient with renal failure. Electrocardiography is recommended for patients undergoing high risk surgery and those undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 55 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed surgical procedure. Therefore the request is not medically necessary.

Post-op occupational therapy 3 times a week for 4 weeks for the right small finger: Upheld

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

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

Decision rationale: Per the CA MTUS/Post-Surgical Treatment Guidelines; Flexor tenosynovectomy [DWC]: Postsurgical treatment: 14 visits over 3 months. Postsurgical physical medicine treatment period: 6 months, Half of the visits are initially recommended pending re-evaluation. In this case the request exceeds the initial recommended treatment number and is therefore not medically necessary.