

Case Number:	CM15-0093178		
Date Assigned:	07/20/2015	Date of Injury:	08/20/2014
Decision Date:	08/14/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	05/14/2015

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 52 year old male, who sustained an industrial injury on 8/20/2014. He reported laceration to the base of his left thumb at the wrist, while using box cutters. The injured worker was diagnosed as having status post laceration of left thenar muscle, rule out median nerve injury, and tenosynovitis of flexor tendon, left middle finger at metacarpophalangeal joint level. Treatment to date has included diagnostics, tendon repair on 8/25/2014, unspecified amount of completed therapy, and medications. Currently, the injured worker complains of some pain in the left hand, as he pointed to the base of the left thenar region. He stated that the pain was not severe, but was associated with numbness of the digits, excluding the pinky finger. He also described pain and pointed to the metacarpophalangeal joint level of the middle finger. Exam of the left hand noted a well-healed scar at the base of the thumb, tenderness in the area of the left middle finger at the metacarpophalangeal joint level flexor aspect, without crepitation or triggering. Opposition of the thumb and fingers was 4+/5 and range of motion showed only minor limitation. The recommended treatment included electrodiagnostic study of the upper extremity, specifically to assess the median nerve of the left hand, and physical therapy for the left hand (2x4). He was noted as released to regular work.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, 2 times per wk for 4 weeks, 8 sessions for Left Hand: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264 265.

Decision rationale: The patient is a 52 year old male with signs and symptoms of possible left carpal tunnel syndrome in the setting of previous tendon repair of the left hand. He continues to have left hand pain, some strength deficit, and possible early trigger finger. He had previously undergone physical therapy following his tendon repair; however, the patient has relatively acute issues in combination with some residual deficit from his initial injury repair. From Chapter 11, ACOEM, page 264, 'If treatment response is inadequate (that is, if symptoms and activity limitations continue), prescribed pharmaceuticals or physical methods may be added.' The patient has continued pain, activity limitation and is being evaluated for possible carpal tunnel syndrome. In addition, from page 265, 'Instruction in proper exercise technique is important, and a physical therapist can serve to educate the patient about an effective exercise program.' Therefore, with the patient's original injury and the additional possible carpal tunnel syndrome, continued pain and possible early trigger finger, a short course of physical therapy with home instruction should be considered medically necessary. Therefore, 8 physical therapy visits should be considered medically necessary. The UR stated that the patient should already be 'well-versed' in an independent home exercise program. However, the patient is well-documented to have additional clinical issues that were not apparently present at the time of his previous physical therapy. Therefore, it is reasonable for the patient to have additional instruction and therapy with respect to these issues.

Left Middle Finger, Cortisone Injection under ultrasound guidance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain chapter - Injection with anesthetics and/or steroids.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271. Decision based on Non-MTUS Citation Corticosteroid injection for trigger finger: blinded or ultrasound-guided injection Cecen GS1, Gulabi D, Saglam F, Tanju NU, Bekler HI. - Arch Orthop Trauma Surg - January 1, 2015; 135 (1); 125-31.

Decision rationale: The patient is a 52 year old male with complaints of possible left carpal tunnel syndrome and pain around the area of A-1 pulley of the left long finger, diagnosed as flexor tenosynovitis. The patient had only demonstrated pain without evidence of triggering. He was noted to have full range of motion. A request had been made for ultrasound guided cortisone injection to the left long finger. The patient may have evidence of an early trigger finger and a cortisone injection could be considered medically necessary. However, the use of ultrasound assisted guidance is not usually customary. From the reference above, there did not appear to be a benefit in using ultrasound assistance. Therefore, without further justification for

the use of ultrasound, this procedure should not be considered medically necessary. ACOEM, Chapter 11, page 271 does allow for trigger finger injection. One or two injections of lidocaine and corticosteroids into or near the thickened area of the flexor tendon sheath of the affected finger are almost always sufficient to cure symptoms and restore function. A procedure under local anesthesia may be necessary to permanently correct persistent triggering.