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Date notice sent to all parties: 03/22/18
IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right small finger tenolysis and capsulectomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Orthopedic Surgery
Diplomate of the American Board of Orthopedic Surgery
Fellow of the of the American Academy of Orthopedic Surgeons
Fellow of the American Association of Orthopedic Surgeons

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Right small finger tenolysis and capsulectomy – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient was discharged on XXXX after sustaining a XX injury. XX had undergone irrigation and debridement on XXXX with Integra placement and wound vac. XX was to wear the wound vac for XX and it would be changed to hydrotherapy. XX then underwent right 5th finger irrigation and debridement and contracture release on XXXX by XX. On XXXX, XX noted the patient was status post reverse finger flap – dorsal ring finger to volar small finger – scar contracture release with placement of Integra to the donor site ring finger. The flap was healthy and viable appearing. The Integra was taking well. XX was scheduled for surgery on XXXX. On XXXX, the right ring finger cross flap to the 5th digits

was viable appearing without evidence of necrosis of the flap. The Integra was in place. Gabapentin would be added for the patient's neuropathic pain. XX then performed STSG on XXXX for the pre and postoperative diagnoses of right hand division of cross finger flap and full thickness skin graft to the finger from the axilla. As of XXXX, XX was doing well and XX had excellent healing of XX skin without signs of infection. The A-cell was removed from the small finger and the nylon sutures were left in place. Sensation was noted to be intact. On XXXX, it was noted XX had not attended occupational therapy yet, as XX had not heard from XX case manager. XX had full range of motion of the ring finger although XX had some difficulty in complete stiffness. Occupational therapy was recommended, which the patient did attend. As of XXXX, XX had received XX of therapy with success. XX was concerned about a ring finger flexion contracture noted at the right small finger DIP joint. XX had full range of motion of the ring finger, but XX did have difficulty with holding some objects. XX was asked to follow-up. On XXXX, additional therapy was recommended. On XXXX, it was noted the patient continued to have a flexion contracture of the right small finger DIP despite multiple surgeries and occupational therapy. Contracture release with right small finger flexor tendon tenolysis with capsulotomy of the right small finger PIP joint was recommended. On XX and XX, Coventry provided utilization review notices, both denying the requested right small finger tenolysis and capsulectomy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The patient is a XX who was XX when XX sustained a degloving injury to the ulnar palmar aspect of XX right hand. XX initially underwent a bedside irrigation and debridement. XX was taken to the operating room on XXXX by XX and underwent right hand irrigation and debridement with Integra placement and placement of a wound VAC. It was reported that XX developed a right fifth digit flexion contracture. XX took XX back to the operating room on XXXX where XX underwent a flexion contracture release that included tenolysis of the flexor digitorum profundus and flexor digitorum superficialis, capsular release of the volar plate of the proximal interphalangeal joint, and cross finger flap. The cross finger flap was then divided on XXXX and split thickness skin grafting was performed. XX was later to begin occupational therapy, but it appeared to be delayed for unclear reasons. Subsequent examination documented 0 degrees of motion at the PIP joint and at least a 45 degree flexion contracture at the distal interphalangeal joint. It is unclear what XX response to occupational therapy was, and he has not returned to work in any capacity. A repeat surgical procedure has been recommended. XX, an orthopedic surgeon, non-certified the request on initial review on XXXX. XX non-certification was upheld on reconsideration/appeal on XXXX by XX. Both reviewers attempted peer-to-peer without success and cited the evidence based Official Disability Guidelines (ODG) as the basis of their opinions.

The evidence based ODG criteria for flexor tenolysis include the following: The patient must be willing to commit to a rigorous course of physical therapy (vigorous postoperative range of motion is required). The patient must have good strength in flexor and extensor muscles of the hand and must have intact nerves to flexor muscles. If the patient has had previous flexor tendon repair, surgery should be delayed until six months postoperative in order to avoid tendon rupture; otherwise, at least three months of conservative treatment, to include physical therapy. 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 range of motion, repeated tenolysis is not indicated. It is 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 in mature previous scars and severe posttraumatic underlying arthrosis. 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 indication when the tendon is not freed completely or when the tenolysis is performed in association with complex orthopedic procedures which do not permit early postoperative active motion.

It is noted that 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 functional 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 can 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 eight months, but ranges 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. (Wheeles 2012, Azari 2005, Tolat 1996, Fetrow 1967) It should be noted the patient sustained a degloving injury to XX right hand almost XX. XX has undergone multiple surgical procedures, to include a prior tenolysis. The ODG does not recommend repeat tenolysis in the face of a failed previous tenolysis. Therefore, the requested right small finger tenolysis and capsulectomy is not appropriate, medically necessary, or in accordance with the ODG and the previous adverse determinations should be upheld at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**