



Lumetra

Brighter insights. Better healthcare.

One Sansome Street, Suite 600
San Francisco, CA 94104-4448

415.677.2000 Phone
415.677.2195 Fax
www.lumetra.com

IRO NOTICE OF DECISION – WC

DATE OF REVIEW: 07-13-2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Surgery to reconstruct the tip of finger, removing nail bed and damaged tissue that is causing pain and infection. Restoring use of finger.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Certified by the American Board of Orthopaedic Surgery
General Certificate in Orthopaedic Surgery

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury Date	Claim #	Review Type	ICD-9 DSMV	Service Units	Upheld/ Overturn
		Prospective	886	1	Overturn

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notification of Determination (05-22-2007 & 06-12-2007)
Occupational Therapy Initial Evaluation (05-03-2007)
Physician Visit Notes (03-30-2007, 04-06-2007)
Radiology Report
Examination Report (05-14-2007)
Physician Order (05-14-2007)
First Report of Injury Receipt

PATIENT CLINICAL HISTORY:

The patient's date of injury was when the tip of the left little finger was smashed in an overhead elevator. The original injury included an open fracture of the distal phalanx of the left small finger with partial amputation. Radiology report showed comminuted open fracture involving the inguinal tuft of the fifth finger. There is near complete soft tissue amputation. The treating physician recommended revision amputation left small finger (outpatient) because of the patient's complaint of continued pain, numbness, and hypersensitivity on the tip of the previously injured left 5th digit.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The Reviewer in this case, a board certified orthopaedic surgeon with a faculty appointment at a major teaching California hospital and former chief of hand surgery at a major teaching hospital with considerable experience in all aspects of hand surgery, determined that the proposed revision surgery is medically necessary.

The Reviewer notes the following:

1. The patient's symptoms have not improved during the three months post injury. This lack of improvement raises the possibility that the patient's symptoms of pain, numbness and hypersensitivity may be result of a condition that may be amenable to surgery, possibly a neuroma.
2. The potential exists for improvement in the patient's symptoms postoperatively as early as 6 weeks after surgical treatment.
3. In light of the patient's usual occupation of manual labor, the opportunity for the patient's earlier return to full employment as a result of revision surgery would likely have beneficial effects beyond improvement in the symptoms directly associated with his finger.

Finally, the reviewer's determination is based on his medical judgment, clinical experience and expertise in accordance with accepted medical standards. His review of the "Official Disability & Treatment Guidelines" (ODG) did not identify a specific recommendation regarding the treatment of this type of injury. Furthermore, he is not aware of any other published literature that indicates that surgical revision of this patient's injury at this time would most likely be of no benefit.

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
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- 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)