MATUTECH, INC.

DATE OF REVIEW: MARCH 26, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OT 3x4 for left wrist – 97110, 97140, 97112, 97530, 97035 and 97032

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

The physician providing this review is an orthopedic surgeon. The reviewer is national board certified in orthopedic surgery. The reviewer is a member. The reviewer has been in active practice for six years.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PT evaluations and examinations (12/03/02 – 05/13/05)
Therapy notes (12/03/02 – 11/28/06)

PT Referral forms (12/19/06 – 01/16/07)

PATIENT CLINICAL HISTORY [SUMMARY]:

This male got hit in his left hand/wrist forcefully by an opening tractor trailer door.

In November 2002, M.D., and Dr. diagnosed carpal tunnel syndrome (CTS). Occupational therapy (OT) evaluation report indicated the following: *History of surgeries: May 20, 2000: Open reduction internal fixation (ORIF). June 25, 2000: Transverse carpal tunnel release (CTR) of the left wrist. January 29, 2001: Deep hardware removal, take down nonunion, fixation nonunion fragments with cancellus screw. June 25, 2001: Left wrist wedge osteotomy and CTR to the right median nerve, followed by physical therapy (PT) through December 2001. Electromyography/nerve conduction velocity (EMG/NCV) studies in September 2002 showed CTS. On November 14, 2002, Dr. performed surgical decompression to the left wrist carpal tunnel and excision of a tumor/soft tissue mass in the forearm. The diagnoses were CTS, nonunion of the left radius, and comminuted left wrist fracture.* From December 2002 through February 2003, the patient attended 24 sessions of OT consisting of fluidotherapy, joint mobilization, massage, iontophoresis, ultrasound, hot packs, therapeutic procedures, and instructions on a home exercise program (HEP). He underwent range of motion (ROM) testing and physical performance evaluation on multiple occasions. The patient received work stimulator, isotoner gloves to include Desert Ice pain-relieving gel and a Neoprene wrist support. In November 2003, Dr. performed hardware removal, median nerve neurolysis, and decompression. The diagnoses were fracture of the shaft of the left radius with ulna, malfunction of internal orthopedic device, and left forearm osteoarthritis. From November 2003 through January 2004, the patient attended 24 sessions of OT consisting of ultrasound, fluidotherapy, therapeutic procedures, massage, galvanic electrical stimulation, therapeutic activities, iontophoresis, and whirlpool.

In January 2005, Dr. diagnosed closed Colles fracture of left wrist and left middle and ring trigger fingers. On January 3, 2005, he performed surgical release of the trigger left middle and ring fingers. From January 2005, through May 2005, the patient underwent 39 sessions of postoperative OT with aforementioned modalities. Pain medications and a transcutaneous electrical nerve stimulation (TENS) unit were continued. On May 16, 2005, Dr. performed left wrist fusion surgery. X-rays showed incomplete healing of the fusion. From May through November, the patient attended 63 sessions of postoperative OT. Pain medications, TENS unit, Lidoderm patch, and Desert Ice pain-relieving gel were continued. Computerized tomography (CT) showed good fusion.

On June 26, 2006, Dr. performed left radioscaphoid fusion with bone graft and removal of screws. The diagnosis was left wrist traumatic arthropathy. The patient was issued a bone growth stimulator and was advised to wear a custom leather volar splint with padding. From October 26, 2006, through November 15, 2006, the patient attended 12 sessions of OT consisting of fluidotherapy, neuromuscular re-education, ultrasound, hot packs, therapeutic activities/exercises, and soft tissue massage. Dr. recommended continuation of PT post fusion to include ROM exercises and strengthening. In December, the OT was denied.

In January 2007, Dr. gave a prescription to continue PT three times a week for four weeks to work on ROM and strength to the left hand digits and wrist. He

noted that the CT in November 2006 had shown good position of the hardware, no loosening, but persistent nonunion between the radius and the scaphoid and good solid union between the radius and the lunate. Dr. evaluation of November 2006 and January 2007, showed restricted ROM. The patient was concerned about the motion about his wrist. On January 23, 2007, the OT request was non-authorized, the reason being that the patient had had a recent surgery and recent x-rays had shown a consolidation of fracture (apparently treated by ORIF). Drs. were contacted. On February 6, 2007, Dr. recommended OT for the left wrist three times a week for four weeks.

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

Although the operative and clinic notes are not available, the above consolidated narrative and the physical therapy notes are available for this review. From these materials it is clear that Mr. clinical course has been long and complicated, ultimately leading to radiocarpal post-traumatic arthrosis. For this diagnosis, Mr. underwent radioscapholunate (RSL) partial wrist arthrodesis. This treatment has been partly successful in that the radiolunate articulation demonstrates union but the radioscaphoid articulation shows no certain union based on CT scan. Although the records do not indicate Dr. decision making process at this time, it is likely that he is trying to maximize Mr. motion and achieve maximal clinical improvement prior to deciding to embark on further surgical revision to achieve union at the radiocarpal articulation. It should be noted that the surgery performed by Dr. was a limited/partial wrist arthrodesis and not a total wrist arthrodesis so at least 50% of full wrist motion can be expected postoperatively and should be maximized by participation in standard hand therapy protocols.

For these reasons it is this reviewers opinion that the request for further therapy is reasonable and necessary and that the previous decision to withhold authorization for this hand therapy should be overturned.

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

The guidelines utilized in arriving at recommendations for this case are based on well established standards recognized within the orthopedic community and supported by professional literature, training standards and experience. Additional referencing is taken from the National Guidelines Clearinghouse at HYPERLINK "http://www.guidelines.gov/"www.guidelines.gov.