

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: APRIL 8, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Two items in dispute:

- 1) Medical necessity of outpatient left hand dorsal capsulotomy, extensor tendonotomy and possible extensor tendon or lengthening all fingers, as requested with CPT code 26520 x 2
- 2) Use of a transcutaneous neurostimulator, as requested with CPT code 64550.

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

M.D., Board Certified Orthopedic Surgeon

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.

Injury Date	Review Type	ICD-9/DSMV	HCPCS/NDC	SERVICE UNITS	Upheld/Overturned
	Prospective	815.03	64450		Upheld
	Prospective	815.03	26520	2	Overturned

The reviewer finds that there is medical necessity for outpatient left hand dorsal capsulotomy, extensor tendonotomy and possible extensor tendon or lengthening all fingers, as requested with CPT code 26520 x 2.

The reviewer finds that there is not medically necessity for use of a transcutaneous neurostimulator, as requested with CPT code 64550.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X-rays right hand, 11/01/06

Operative report, 11/03/06

X-rays left hand, 11/27/06

Office notes, Dr., 03/26/07, 06/20/07, 09/19/07, 02/20/08

Disability determination, Dr., 06/26/07

Adverse Determination Letter, Dr., 02/28/08

Adverse Determination Letter, Dr., 03/14/08

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year-old, right hand dominant male xxx who on xx/xx/xx sustained a crush injury to his left hand. He was found to have displaced fractures of the second through fifth metacarpals. On xx/xx/xx he underwent an incision and drainage to the bone of the open fractures of the left hand, intramedullary fixation of the left middle finger metacarpal shaft, intramedullary fixation of the left ring finger metacarpal shaft and of the left fifth metacarpal shaft. On 11/03/06 he underwent a wound examination and debridement of the skin, fascia, subcutaneous tissue and a small amount of tendon, manipulation of the metacarpal phalangeal and interphalangeal joints of all four digits and manipulation under anesthesia of 12 joints due to the formation of contractures. A splint was placed. The postoperative diagnoses included a crush injury of the left wrist and hand with two fractures of the mid shaft metacarpals of all four digits, previously pinned with extensor indices proprius tendon injury, significant dorsal crush injury to the soft tissues, skin and subcutaneous tissue with transverse laceration of 5.5 to 6.0 inches in length and stiffness in the metacarpal phalangeal and interphalangeal joints of all digits.

On 11/07/06 the claimant underwent an irrigation and debridement of the left hand wound down to the muscle and delayed primary closure of the open wound. X-rays of the left hand on 11/27/06 revealed multiple fractures of the metacarpals with internal orthopedic fixation. There was no callus formation.

On 03/26/07 Dr. orthopedic surgeon evaluated the claimant at which time he had gradually improving range of motion and decreasing swelling. The claimant was doing most of his exercises at work and had gained the ability to grip and shake hands. He had decreased pain but was still markedly limited with the metacarpal phalangeal joint contractures. Examination noted extension of the left wrist 35 degrees, flexion 40-45 degrees, radial deviation of 10 degrees and ulnar deviation of 15 degrees. He lacked full metacarpal joint motion by 35-40 degrees lacking full flexion. All wounds were healed, wrinkle pattern was reappearing and he had improved sensation on each palmar digits. Continuation of therapy with most of this at work

and followup in several months were advised. If he was not improving consideration would be given to a metacarpal joint capsulectomy.

By the 06/20/07 visit he was noted to have very slow, but specific improvement in tissue viability, flexibility and loosening. He was working with exercises but due to the metacarpal joint tightness and lack of full flexion at the metacarpal joints had not been able to progress. At one year post injury a dorsal capsulotomy was to be recommended if he had not gained more motion. On 06/26/07 Dr. evaluated the claimant for a disability determination. He reported left hand pain with weakness. There was a deformity of the left hand, contractures of the second through fifth fingers of the left hand, decreased grip and pinch strength on the left compared to the right and 2 point discrimination of 9 millimeters in all the fingers on the left. Dr. deemed the claimant at Maximum Medical Improvement as of that date and assigned her a 29 percent whole person impairment rating.

On 09/19/07 Dr. re-evaluated the claimant. He had much better motion, but had tight metacarpal joint capsules with only between 30-45 degrees of the metacarpal joint motion. The examination noted 15-20 degrees angular rotation of the small finger which may or may not be corrected by capsulotomy. He had no grip problems, continued metacarpal joint stiffness, more mobility of the interphalangeal joints and some prominent but not painful subluxation of the carpometacarpal joints. The metacarpal phalangeal joints were contracted. X-rays of the wrist and possible capsulotomy were recommended.

On 02/20/08 the claimant presented again to Dr. reporting problems with attempts at gripping. He had not had improvement with therapy for a considerable number of months, was unable to bring his fingers to the distal palmar crease and could not flex the metacarpal phalangeal joints enough to where he could have a power grip with the left hand despite compliance with his care. On examination he had only 50-60 degrees of metacarpal phalangeal joint flexion of the small and ring fingers, 60-65 degrees of the index and long fingers and lacked fingertip to palm flexion of the small and ring fingers, but could barely get the index and long fingers to the palm, but only to the proximal palm. He had difficulty with power grip due to stiffness. When passive motion was done on each digit he had pain over the metacarpal phalangeal joints and stated this area was the most uncomfortable but he could fully extend the index and long fingers. He lacked approximately 10 degrees of full metacarpal interphalangeal joint extension of the small and ring fingers, had a rotational deformity of his small finger as it overlapped which appeared to be due to a contracture on the ulnar side of the small finger. Multiple contractures due to the crush injury with extensor tendon involvement, crush injury with large dorsal wound and secondary contractures and apex dorsal angulation and callus on the dorsum with a slight bowed appearance were diagnosed. Dr. indicated that part of the lack of full flexion may be from the extensor tendon adhesions but was most likely related to the metacarpal phalangeal joint tight dorsal capsules. Dr. recommended release of the extensor mechanism and dorsal capsulotomies of the metacarpal phalangeal joint. The surgery was denied by two reviewers on 02/28/08 and 03/14/08 and is currently under dispute.

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

The reviewer finds that there is medical necessity for outpatient left hand dorsal capsulotomy, extensor tendonotomy and possible extensor tendon or lengthening all fingers, as requested with CPT code 26520 x 2.

The reviewer finds that there is not medically necessity for use of a transcutaneous neurostimulator, as requested with CPT code 64550.

The claimant had an initial injury in xx/xx/xx and underwent three subsequent surgeries. The claimant has persistent diminished metacarpophalangeal flexion despite physical therapy. The claimant was evaluated by Dr., and the lack of flexion was thought to be secondary to extensor tendon adhesions or metacarpophalangeal dorsal capsular tightness. The claimant has clinical symptoms of diminished power grip, and has been noted consistently to have diminished grip strength. The claimant still has deficits of metacarpophalangeal flexion of the small and ring fingers, which would be responsible for grip strength and power grip. The claimant has only 50 to 60 degrees of metacarpophalangeal flexion which could account for the clinical symptoms and grip weakness. The surgery itself would therefore seem reasonable.

However, the reviewer is unable to justify the use of a transcutaneous neurostimulator as requested with CPT code 64550. The rationale for such neurostimulator placement is unclear.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, (i.e. Forearm, Wrist and Hand – Tendon Repairs)
Orthopedic Knowledge Update, 8, Chapter 53, pages 638-639

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)