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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 25, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Fusion of distal interphalangeal (DIP) joint of the right small finger (26860)

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

Board Certified Orthopedic Surgery
Hand Specialist

REVIEW OUTCOME

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of Fusion of distal interphalangeal (DIP) joint of the right small finger (26860)

ODG have been utilized for denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx. He was polishing a die on a lathe at work when his hand slipped into the chuck. He broke three fingers of the right hand including the little finger.

Following the injury, the patient was treated with a full-length finger splint for about six weeks but had no improvement in the extension lag at the distal interphalangeal (DIP) joint of the right small finger. M.D., a hand surgeon, noted well healed scar over the dorsum of the DIP joint of the small finger. The scars appeared clearly jagged and appeared more than one but certainly could have extended over the entire extension tendon insertion region. There was still some significant swelling on the distal phalanx and the DIP joint itself. The DIP joint showed a 45-50 degree extension lag. X-rays revealed fractures at the tufts of the index and small fingers and overall satisfactory position. The proximal interphalangeal (PIP) joint did showed some stiffness only to about 70 degree with full extension. Dr. assessed right small finger mallet injury with a history of

possibly and actual open laceration of the extensor tendon versus a closed avulsion. His treatment plan was: *"The degree of injury to his finger is much later that closed terminal extensor tendon fracture. With the history of the open laceration as well as the fracture he probably less likely to have a successful outcome with just splinting but I think there is a reasonable chance that would be successful. If conservative treatment is not effective, then we could certainly proceed with surgical intervention. I have never had any luck with any of the off-the shelf type splints and although a simple theory, maintaining the joint in absolute maximum extension and even with a bit of hyperextension is quite hard to accomplish in real life. In addition, you want to leave the proximal interphalangeal joint free or it results in unacceptable stiffness at that level. We will try a more exact splinting technique for couple of weeks and see if we have any improvement."*

The patient failed the closed management.

On May 22, 2008, Dr. performed reconstruction of extensor tendon with imbrication as well as extensor tendon tenolysis. Postoperative diagnosis was laceration with some substance loss of the terminal extensor tendon of the right small finger with significant extensor tendon adhesions. In June, he removed the K-wires.

On July 1, 2008, Dr. noted that the droop was definitely worsening. There was an extension lag of good 40-50 degrees. There was no significant active extension. He assessed questionable failure of reconstruction of extensor tendon either due to adhesions or stretching of the tendons. He recommended trial of splinting for another three to four weeks to see if it could help and then considering a formal fusion of the DIP joint.

On July 21, 2008, M.D., denied the fusion of DIP joint of the right small finger with a following rationale: *"the request for fusion of the DIP joint of the right small finger is not seen as medically necessary and medically indicated at this time. Official Disability Guidelines (ODG) notes that patient may have functional limitations due to fusion that interfere with their lifestyle and total fusion does not always result in complete pain relief. While arthrodesis does provide a pain free stable joint of motion, it should only be indicated in young patients' in whom heavy loading is likely and in patient's with joints that have a fixed painful deformity, instability, or loss of motor function. This patient has only recently begun PT. There are no PT reports included for review to document his progress with conservative measures. There are no imaging studies submitted for review. There is no operative report included for review. Based on the clinical information provided, the request for fusion of the DIP joint of the right small finger is not seen as medically necessary at this time."*

On July 31, 2008, M.D., denied the request for reconsideration of the fusion surgery with a following rationale: *"The claimant had surgery in May with a pin placed and then had the pin and k-wires removed in June 2008. The claimant was started in gentle ROM exercises in June 2008; however, by July 2008 there was a question of failure of the construction of the extensor tendon repair due to adhesions or stretching of the tendon. Splinting was recommended and consideration of fusion of the DIP joint was mentioned. At this point, it is unclear*

whether the splinting has succeeded in correcting the droop and additional surgery is not indicated.”

On August 4, 2008, the patient wrote a letter in which he stated: “I was referred to Dr. He placed my finger in a simple metal brace and stated that tendon would reattach with this treatment. I returned to Dr. office six times in five months with no change in the pain or the shape of the finger. I repeatedly asked to refer me to a new doctor. Finally, was referred to Dr.. He performed surgery to reattach the tendon and stated that it would take eight weeks for the finger to heal. During the five months of ineffective treatment, the tendon had grown back to the joint not the fingertip. He cut the tendon away from the bone and reattached it to the fingertip. He put a pin in the finger to hold it straight. He also placed the finger in splint to assure the finger remained stationary. After eight weeks, he removed the pin. As we discussed further treatment, the tendon came apart and the pain and the crook returned. Dr. stated that the tendon had deteriorated over the five months. Dr. treated it and if the surgery had been performed within one to two weeks of the injury, there would have probably been a 100% recovery. Dr. stated that the only option now to relieve the pain is to fuse the bone at the upper joint with a permanent screw to keep it straight.”

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

It appears that fusion of the distal interphalangeal joint is not reasonable and appropriate as on 05/22/08 he underwent reconstruction of extensor tendon imbrication, extensor tenolysis and pinning, however, he has had persistent failure of this. Given this attempt at surgical procedure, his sutures were removed only four weeks postoperatively. It is also clear that splinting had worked as well as secondary attempt to get this to heal. Based on this I do not think that it is reasonable or appropriate as we do not know the outcome of splinting that was most recently recommended. This result should be reviewed prior to recommending additional surgery.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES