

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 27, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Dorsal capsulotomy left long and ring PIP 26525

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.

The reviewer finds that medical necessity does not exist for Dorsal capsulotomy left long and ring PIP 26525.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old female who sustained a crush injury to the left hand on xx/xx/xx when her hand was pulled into a machine. Injuries included open fractures involving the ring and long finger proximal phalanges, amputation of the tip of the ring and long fingers, a completely displaced fracture of the thumb and proximal phalangeal neck. She underwent open reduction and internal fixation of the fractures and tendon repairs.

The claimant treated with Dr. initially. Records from 09/20/06 indicate that she developed reflex sympathetic dystrophy and underwent blocks and treatment with pain management. She underwent physical therapy. On 11/30/06 Dr. saw the claimant for a second opinion. She had developed moderate flexion contractures of the ring, long and small fingers. She had a little atrophy of the fat pad and finger pad on the ring and long finger. It

was noted that she had gotten over most of the allodynia and hyperesthesia and most of the pain was with passive attempts to stretch the digit. X-rays showed good alignment of the fractures involving the thumb and proximal phalangeal neck and the proximal phalanges of the ring and long fingers. Physical therapy was continued and Dr. felt that open releases would not be of much benefit and could flare her reflex sympathetic dystrophy.

On 02/08/07 Dr. discussed different treatment options for the finger stiffness including capsulotomies but felt that with her history of reflex sympathetic dystrophy and with the fractures near the joints and the extreme atrophy and stiffness of the joints and the skin, he did not think she would be a good candidate for surgery. On exam she had tight, shiny, atrophied skin from the PIP level distally on the ring and long fingers. The ring proximal interphalangeal (PIP) joint went from 45-70 degrees; the long PIP joint went from 50-70 degrees. The small finger only went from 0-60 degrees. She was neurologically decreased distal to the level of crush on both the ring and long fingers. She was to return to work as previous and the physician noted a poor prognosis for repeat surgery with the combined injury and with the reflex sympathetic dystrophy.

On 04/10/08 Dr. noted that the left ring and long fingers went from 45 degrees to 70 degrees. She still had atrophy of the two fingers. He noted that the amputation was at the very tip with a little bit of loss of the palmar pad and mild parrot deformity of the nail plate. She had mild allodynia and hyperesthesia of both fingers. Dr. noted that surgical release of the contracture would give her about 30% improvement of range of motion. He recommended NSAIDS and continued stretching and strengthening program.

At the visit of 06/19/08 the claimant wished to proceed with release of the dorsal capsule, as her main complaint was not the flexion contracture but the fact that she could not flex the fingers down equally with the index and small fingers. The claimant had 45-70 degrees of motion in the ring and long finger. Passively she had excellent range of motion of the index, small finger and thumb. Her only limitation to flexion of the index and small fingers was due to the stiffness of the ring and long fingers. The physician recommended a dorsal capsulotomy of the PIP joint of the left ring and long fingers.

Dr. specified at the office visit of 07/17/08 that the claimant had amputation of the tip of the ring finger and long finger only involving the very tuft of the digit as her nail was still intact. The DIP, PIP and MP joints were still intact. He documented active motion of 45 degrees to 60 degrees on the ring and long fingers and passively 45 to 70 degrees. When she made a fist she was still several centimeters from touching the palm due to the lack of flexion at the PIP and DIP joints. He felt that a dorsal capsulotomy of the PIP would get her down to about 90 degrees at the PIP so that she would be able to crawl her hand around moderate sized objects such as the steering grip of a car. He felt that getting the PIP joints flexed a little bit more would be of significant improvement for her functionally. He noted that she had no allodynia or hypesthesias or signs of reflex sympathetic dystrophy. The surgery was denied on peer reviews of 07/03/08 and 08/05/08.

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

The requested dorsal capsulotomy left ring and long finger PIP joint is not medically necessary based on review of this medical record.

Clearly, this person had a significant injury in xxxx, and there are multiple office visits from Dr. who initially indicates that further surgery would not be appropriate, and then a 07/17/08 office visit of Dr. who discussed the need for capsulotomy PIP, ring, and long

fingers.

There are peer reviews from Dr. and Dr. who indicate surgery is not appropriate and a discussion by Dr. of an independent medical evaluation of Dr. who documented hand contractures and depression with significant atrophy. The independent medical evaluation by Dr. was not included in the medical records reviewed.

In light of the fact that the independent medical evaluation of Dr. is not present, and the fact there is obviously a difference of opinion between the physicians as to whether or not surgical intervention is necessary, and the fact that the claimant is two years after injury and may in fact not have improvement with capsulotomy, there is not enough information in these medical records to determine that the surgery is needed.

The reviewer finds that medical necessity does not exist for Dorsal capsulotomy left long and ring PIP 26525.

Official Disability Guidelines do not address the surgical procedure.

Green's Operative Hand Surgery, 5th edition; chapter 11, pages 429-433

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: Green's Operative Hand Surgery, 5th edition; chapter 11, pages 429-433

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**