

## Notice of Independent Review Decision

### DATE OF REVIEW:

02/27/2008

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left ring finger amputation revision with direct closure (26951).

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

Board Certified Orthopaedic Surgeon

### REVIEW OUTCOME

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

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.

**Left ring finger amputation revision with direct closure (26951) is not medically necessary.**

### INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MCMC: Case Report dated 02/15/08
- MCMC Referral dated 02/15/08
- DWC: Notice To MCMC, LLC Of Case Assignment dated 02/15/08
- DWC: Notice Of Assignment Of Independent Review Organization dated 02/15/08
- DWC: Confirmation Of Receipt Of A Request For A Review dated 02/14/08
- LHL009: Request For A Review By An Independent Review Organization dated 02/08/08
- Letter dated 01/11/08, M.D.
- Letter dated 01/09/08, M.D.
- Utilization Review Referrals dated 01/03/08, 11/26/07
- M.D.: Letter dated 12/28/07
- M.D.: Surgery Scheduling Form dated 12/07/07
- Letters dated 11/29/07 (two) from, M.D.
- M.D.: Therapy Prescription dated 11/20/07
- M.D.: Surgery Scheduling Form dated 11/20/07
- M.D.: Follow-Up visit note dated 11/20/07
- M.D.: EMG/Nerve Conduction study report dated 11/08/07
- M.D.: Electrodiagnostic Study Request dated 10/18/07
- Electrodiagnostic Study Request dated 10/18/07 from, M.D.
- M.D.: New Patient Visit dated 10/18/07
- M.D.: Consultation Request dated 09/25/07

- Advanced Pain Management: Office notes dated 09/19/07, 08/23/07, 07/25/07, 06/13/07 from M.D.
- M.D.: Surgery report dated 06/01/07
- M.D.: Interdisciplinary Assessment dated 05/17/07
- NOTE: Carrier did not supply ODG guidelines.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

There is no information regarding the initial stages of treatment following the work-related injury of xx/xx/xx. The first medical record is dated xx/xx/xx. It was an evaluation performed by M.D., a pain management physician. His initial diagnosis was Reflex Sympathetic Dystrophy/Complex Regional Pain Syndrome (CRPS) following a traumatic partial amputation to the left ring finger. The injury was reported to have occurred on xx/xx/xx when the injured individual was getting down off a backhoe. He put his hand on the tread to steady himself and his hand got stuck. There is no information regarding the initial treatment except that the wound was closed with sutures. Dr. performed a stellate ganglion block on 06/01/2007. He reported on 06/15/2007 that the injured individual had no improvement following the block. It was noted that the injured individual was undergoing some form of therapy during this time. The injured individual was placed on trials of Lyrica and Neurontin without improvement. Dr. on 09/19/2007 recommended the injured individual seek another opinion since he was not responding and questioned the diagnosis of CRPS. An electromyogram/nerve conduction velocity (EMG/NCV) study was interpreted by M.D on 11/08/2007 as consistent with left median neuropathy. The study appeared to be only slightly abnormal. Mr. was seen by M.D., a hand surgeon, on 11/20/2007. Dr. eventually recommended an endoscopic carpal tunnel release and a revision amputation of the left ring finger. He opined that the carpal tunnel syndrome was aggravating the injured individual's CRPS. There is no mention of the injured individual's response to carpal tunnel injection. An initial peer review was performed on 11/29/2007 and denied because it was unclear how the procedure would benefit the injured individual. authored a letter on 01/11/2008 as treating physician disputing the finding of maximum medical improvement (MMI). He felt that the injured individual required additional treatment. He noted that the injured individual had been seen by Dr. and Dr. who had recommended no revision of the amputation. The requested procedure was denied on reconsideration/appeal on 01/09/2008. The reviewer felt that the main reason for the request was continued pain and was unclear how the surgery would resolve the CRPS.

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

The injured individual is a xx-year-old male who was reported to have sustained a partial amputation to the left ring finger as a result of a work-related injury of xx/xx/xx. Initial documentation regarding treatment is not available. He is one-year status-post injury and has continued to complain of pain. He has not returned back to work in any capacity since injury. He has undergone pain management to include stellate ganglion block, medication management, and some form of therapy without any documented objective evidence of clinical improvement. Dr., his pain management physician reported back in 09/2007 that his diagnosis of Complex regional pain syndrome (CRPS) was unclear. Dr. has subsequently requested a surgical procedure, which at some point has included endoscopic carpal tunnel release and revision amputation. There is no information regarding the results of a three-phase bone scan or carpal tunnel injection.

**Official Disability Guidelines:**

CRPS, diagnostic criteria	<p>Under study. There are no objective gold-standard diagnostic criteria for CRPS I or II.</p> <p><b>A. CRPS-I (RSD):</b>          The IASP (International Association for the Study of Pain) has defined this diagnosis as a variety of painful conditions following injury which appear regionally having a distal predominance of abnormal findings, exceeding in both magnitude and duration the expected clinical course of the inciting event and often resulting in significant impairment of motor function, and showing variable progression over time. (<a href="#">Stanton-Hicks, 1995</a>)          Diagnostic criteria defined by IASP in 1995 were the following: (1) The presence of an initiating noxious event or cause of immobilization that leads to development of the syndrome; (2) Continuing pain, allodynia, or hyperalgesia which is disproportionate to the inciting event and/or spontaneous pain in the absence of external stimuli; (3) Evidence <i>at some time</i> of edema, changes in skin blood flow, or abnormal sudomotor activity in the pain region; &amp; (4) The diagnosis is excluded by the existence of conditions that would otherwise account for the degree of pain or dysfunction. Criteria 2-4 must be satisfied to make the diagnosis. These criteria were found to be able to pick up a true positive with few false negatives (sensitivity 99% to 100%), but their use resulted in a large number of false positives (specificity range of 36% to 55%). (<a href="#">Bruehl, 1999</a>) (<a href="#">Galer, 1998</a>) Up to 37% of patients with painful diabetic neuropathy may meet the clinical criteria for CRPS using the original diagnostic criteria. (<a href="#">Quisel, 2005</a>) To improve specificity the IASP suggested the following criteria: (1) Continuing pain disproportionate to the inciting event; (2) A report of one <i>symptom</i> from each of the following four categories and one <i>physical finding</i> from two of the following four categories: (a) Sensory: hyperesthesia, (b) Vasomotor: temperature asymmetry or skin color changes or asymmetry, (c) Sudomotor/edema: edema or sweating changes or sweating asymmetry, or (d) Motor/trophic: reports of decreased range of motion or motor dysfunction (weakness/tremor or dystonia) or trophic changes: hair, nail, skin. This decreased the number of false positives (specificity 94%) but also decreased the number of true positives (sensitivity of 70%). (<a href="#">Bruehl, 1999</a>)  <u>The Harden Criteria</u> have updated these with the following four criteria: (1) Continuing pain, which is disproportionate to any inciting event; &amp; (2) Must report at least one symptom in three of the four following categories: (a) Sensory: Reports of hyperesthesia and/or allodynia; (b) Vasomotor: Reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry; (c) Sudomotor/Edema: Reports of edema and/or sweating changes and/or sweating asymmetry; (d) Motor/Trophic: Reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin); &amp; (3) Must display at least one sign at time of evaluation in two or more of the following categories: (a) Sensory: Evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or temperature sensation and/or deep somatic pressure and/or joint movement); (b) Vasomotor: Evidence of temperature asymmetry (&gt;1°C) and/or skin color changes and/or asymmetry; (c) Sudomotor/Edema: Evidence of edema and/or sweating changes and/or sweating asymmetry; (d) Motor/Trophic: Evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin); &amp; 4. There is no other diagnosis that better explains the signs and symptoms (<a href="#">Harden, 2007</a>)  <u>The Washington State Department of Labor and Industries</u> guidelines include the presence of four of the following physical findings: (1) Vasomotor changes: temperature/color change; (2) Edema; (3) Trophic changes: skin, hair, and/or nail growth abnormalities; (4) Impaired motor function (tremor, abnormal limb positioning and/or diffuse weakness that can't be explained by neuralgic loss or musculoskeletal dysfunction); (5) Hyperpathia/allodynia; or (6) Sudomotor changes: sweating. Diagnostic tests (only needed if four physical findings were not present): 3-phase bone scan that is abnormal in pattern characteristics for CRPS. (<a href="#">Washington, 2002</a>)  <u>The State of Colorado Division of Workers' Compensation Medical Treatment Guidelines</u> </p>
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adopted the following diagnostic criteria in 2006: (1) The patient complains of pain (usually diffuse burning or aching); (2) Physical findings of at least vasomotor and/or sudomotor signs, allodynia and/or trophic findings add strength to the diagnosis; (3) At least two diagnostic testing procedures are positive and these procedures include the following: (a) Diagnostic imaging: Plain film radiography/triple phase bone scan, (b) Injections: Diagnostic sympathetic blocks, (c) Thermography: Cold water stress test/warm water stress test, or (d) Autonomic Test Battery. The authors provide the following caveat: Even the most sensitive tests can have false negatives, and the patient can still have CRPS-I, if clinical signs are strongly present. In patients with continued signs and symptoms of CRPS-I, further diagnostic testing may be appropriate. ([Colorado, 2006](#))

Other authors have questioned the usefulness of diagnostic testing over and above history and physical findings. ([Quisel, 2005](#)) ([Yung, 2003](#)) ([Perez2, 2005](#)) A negative diagnostic test should not question a clinically typical presentation of CRPS and should not delay treatment. ([Birklein, 2005](#))

**B. CRPS-II (causalgia):**

Nerve damage can be detected by EMG but pain is not contained to that distribution. ([Stanton-Hicks, 1995](#)) CRPS I and II appear to be clinically similar. ([Bruehl, 1999](#)) CRPS-II is defined by the IASP as: (1) The presence of continuing pain, allodynia, or hyperalgesia after a nerve injury, not necessarily limited to the distribution of the injured nerve; (2) Evidence at some time of edema, changes in skin blood flow, and/or abnormal sudomotor activity in the region of pain; & (3) The diagnosis is excluded by the existence of conditions that would otherwise account for the degree of pain and dysfunction. The state of Colorado also uses the above criteria but adds that there must be documentation of peripheral nerve injury with pain initially in the distribution of the injured nerve. ([Colorado, 2006](#))

**C. Differential Diagnoses of CRPS**

These need to include local pathology, peripheral neuropathies, infectious processes, inflammatory and vascular disorders. ([Quisel2, 2005](#)) ([Stanton-Hicks, 2006](#)) Also include the following conditions: pain dysfunction syndrome; cumulative trauma syndrome; repetitive strain syndrome; overuse syndrome; tennis elbow; shoulder-hand syndrome; nonspecific thoracic outlet syndrome; fibromyalgia; posttraumatic vasoconstriction; undetected fracture; post-herpetic neuralgia; diabetic neuropathy. ([Stanton-Hicks, 2004](#)) See also [Treatment for CRPS](#); [Sympathetically maintained pain \(SMP\)](#); [CRPS, medications](#); [CRPS, prevention](#); [CRPS, sympathetic and epidural blocks](#).

The injured individual's diagnosis is unclear at best. He has had a protracted course. There is no information specifically addressing potential psychosocial issues that may be impeding functional restoration. It is unclear how the proposed surgery would resolve his complaints and not potentially worsen his condition.

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

- **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**