COMPPARTNERS

URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: **8/5/09**

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for therapy for stiff digit following a crush injury.

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

A Texas licensed Orthopedic Surgeon

REVIEW OUTCOME:

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

X 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 previously denied request for therapy for stiff digit following a crush injury.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) Form dated 7/28/09.
2. Notice to . of Case Assignment Sheet dated 7/29/09.
3. Fax Cover Sheet dated 7/29/09.
4. Case Information Sheet dated 7/29/09.
5. Request Form/Request for a Review by an Independent Review Organization Form dated 7/27/09.
6. Patient Medical History Report dated 7/8/09.
7. Consultation Report dated 7/6/09.
8. Physical Examination Report dated 7/8/09.
9. Prescription for Referral Sheet dated 6/25/09.
10. Physical Examination Form 6/26/09, 6/8/09(unspecified date).
11. Report dated 6/23/09, 6/8/09, 6/2/09
12. Study Note dated 6/24/09.
13. Radiology Report dated 6/23/09, 6/2/09.
14. Medicare Policies and Guidelines/Letter dated 8/3/09.
15. Integrated Treatment/Disability Duration Guidelines (unspecified date).
16. Physical/Occupational Therapy Guidelines (unspecified date).
17. Fax Cover Sheet/Pre-Authorization Request (unspecified date).
18. Physical Therapy Request Sheet (unspecified date).
19. Patient Information sheet (unspecified date).
20. Physical Therapy-initial Evaluation Sheet (unspecified date).
21. Request for Pre-Certification Sheet (unspecified date).
22. Occupational Sheet dated 7/6/09.
23. Referral Prescription Sheet (unspecified date).
24. Range of Motion Measurements Exam (unspecified date).
25. Fax Cover Sheet/Patient Information Note dated 7/16/09.
26. Pharmacy Benefit Card/Prescription dated 6/2/09.
27. Adverse Determination after Reconsideration Notice dated 7/22/09.
28. Adverse Determination Notice dated 7/15/09.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: **xx years old**
Gender: **Female**
Date of Injury: **xx/xx/xx**
Mechanism of Injury: **Crush injury**
Diagnosis: **Contusion of her hands/fingers and strain of her finger.**

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

The claimant is a xx year-old, right hand dominant female who sustained a crush injury to her right hand and fingers on xx/xx/xx when a cooler door shut on her hand. She was diagnosed with a contusion of her hand/fingers and strain of her finger. Dr. l saw her on xx/xx/xx, at which time she had mild tenderness and swelling. A metal arm splint was applied, some form of injection was given and Darvocet prescribed. X-rays of the right hand taken that day showed no fracture. She was released to work with restrictions. At the 06/08/09 visit she reported swelling, weakness and pain of the right hand and pain in the third digit of the right hand. This report was hard to read. Mild tenderness and restricted motion were noted. Discontinuation of the splint was recommended. Ibuprofen and Darvocet were prescribed. The claimant started therapy on 06/16/09. The claimant was re-evaluated on 06/23/09 noting decreased motion, swelling of the third digit and numbness of the second digit of the right hand. Full motion was noted. She was referred to a hand surgeon. X-rays that day showed no fracture. Dr. saw the claimant on 07/06/09 noting the claimant had attended 9 visits of therapy. She reported no improvement of her symptoms. She complained of numbness, pain and stiffness of the digits and worse symptoms with motion. The examination showed no swelling, limited motion, incomplete fisting and pressure changes on the middle finger (MF) due to the splint. Stiff fingers and a contusion of the hand were diagnosed. Additional therapy and off work were recommended. A therapy note dated 07/08/09 noted protective positioning of the right hand, edema of the fingers, especially the MF and proximal interphalangeal (PIP). She was able to oppose all digits and had very slow and careful motion and manipulation of objects. Motion of the right index finger was: metacarpal phalangeal (MCP) extension 0 degrees, flexion 70 degrees, PIP extension 0 degrees, flexion 80 degrees, distal interphalangeal (DIP) extension 0 degrees and DIP flexion 10 degrees. Right middle finger motion was: MCP extension 0 degrees, MCP flexion 65 degrees, PIP extension minus 13 degrees, PIP flexion 85 degrees, DIP extension 20 degrees and DIP flexion 32 degrees. Motion of the right ring finger was: MCP extension 0 degrees, MCP flexion 60 degrees, PIP extension minus 14 degrees, PIP flexion 90 degrees, DIP extension 0 degrees and DIP flexion 35 degrees. Motion of the right little finger was: MCP extension 0 degrees, MCP flexion 60 degrees, PIP extension minus 5 degrees, PIP flexion 84 degrees, DIP extension 0 degrees and DIP flexion 36 degrees. Reviews for 12 additional visits of therapy on 07/15/09 and 07/22/09 denied the request. Just over two months have passed since this injury. No fractures were documented. No significant soft tissue disruption has been documented. Despite the absence of significant injury, the subjective symptoms did not appear to be improved by nine sessions of therapy. This reviewer is not able to recommend as medically necessary the proposed additional therapy in this case. It does not appear that the previously prescribed therapy changed the subjective symptoms. In the absence of significant soft tissue injury and in the absence of fracture, one would certainly have concerns as to nonorganic manifestations after the

passage of over two months. The documentation provided does not support the request for additional therapy and does not meet the ODG guidelines.

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

□ ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

Official Disability Guidelines (ODG), Treatment Index, 7th Edition (Web), 2009, Forearm/ Wrist/Hand – Physical therapy.

□ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

□ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).