

MEDR X

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AMENDED REPORT of 12/24/09 Notice of Independent Review Decision

DATE OF REVIEW: 12/24/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under dispute include the medical necessity of a revision amputation of the left ring finger.

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

The reviewer is a Medical Doctor who is a board certified Orthopedic Surgeon. This physician has been in active practice for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the medical necessity of a revision amputation of the left ring finger.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
MD and.

These records consist of the following (duplicate records are only listed from one source):
Dr.: handwritten chart notes by Dr. from 7/1/09 to 11/9/09, 7/8/09 history form, OT discharge summary of 11/26/09, OT data forms from 8/12/09 to 11/20/09, OT progress reports 9/23/09 to 10/22/09, 8/20/09 OT approval, 8/12/09 OT eval, 8/14/09 OT eval, therapy request form of 7/8/09, operative report of 6/10/09 and 7/8/09 operative report.: 11/30/09 denial letter,

11/13/09 denial letter, surgery posting form (undated), OT treatment flow sheet from 8/12/09 to 10/22/09 and Bay Area Progress notes 10/19/09 to 10/22/09.

We did not receive the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

Records reviewed included notes from Dr, the attending physician. "Extreme sensitivity to pressure" was noted at the ring finger tip s/p partial finger amputation. No exam findings were provided. A bone shortening osteotomy" procedure has been considered by the AP. Prior therapy records were also reviewed as was the 6/10/09 dated AP operative report revealing an open extensor mechanism repair and revision amputation at the DIP joint of the ring finger, among others. The injuries had been industrial machine associated and traumatically induced. In a therapy record from 10/22/09, hypersensitivity had been noted to have been "decreased."

A (Coventry) review by a Dr. dated 11/19/09, was noted. "Vague" AP notes, the lack of imaging study report(s) and non-op. treatment for hypersensitivity were all cited as rationale for a non-cert. A prior note of 11/13/09 (Concentra) review was noted to be from a Dr. The lack of exam findings and/or evidence of failure of non-op treatment was noted as the non certification rationale.

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

The documentation (subjective) is inconsistent with continual hypersensitivity (therapist records differ from AP's) and (objective) exam findings haven't been provided referencing severity of tenderness, swelling, bony soft tissue impingement, presence of Tinel's sign (neuroma), etc. Failure of specific therapy techniques, local adaptive devices and/or meds. designed to reduce sensitivity have not been documented. While "shortening osteotomy" of bone shortening is not uncommon on a secondary-delayed basis, the documentation is insufficient to support same in this case.

The ODG does not have an opinion regarding this procedure; therefore, other sources were utilized. Fassler PR Fingertip Injuries: Evaluation and Treatment. J Am Acad Orthop Surg. 1996 Jan;4(1):84-92.

The primary goal of treatment of an injury to the fingertip is a painless fingertip with durable and sensate skin. Knowledge of fingertip anatomy and the available techniques of treatment is essential. For injuries with soft-tissue loss and no exposed bone, healing by secondary intention or skin grafting is the method of choice. When bone is exposed and sufficient nail matrix remains to provide a stable and adherent nail plate, coverage with a local advancement flap should be considered. If the angle of amputation does not permit local flap coverage, a regional flap (cross-finger or thenar) may be indicated. If the amputation is more proximal or if the patient is not a candidate for a regional flap because of advanced age, osteoarthritis, or other systemic condition, shortening with primary closure is preferred.

Gross SC, Watson HK Revision of painful distal tip amputations. Orthopedics. 1989 Dec;12(12):1561-4.

- Orthopedics. 1990 Nov;13(11):1204.

From 1968 to 1987, 22 patients were diagnosed with dysfunctioning digits after complete distal digital amputations. Each patient had the proximal portion of the partially amputated phalanx left within the injured digit. On average, 21 months after the initial injury, each patient underwent an excision of the remnant portion of the phalanx which averaged 6 mm (range 1 to 17 mm). All 22 patients reported excellent postoperative results of full function and no residual pain with an average follow up of 9 months. We theorized that localized synovitis produces joint pain related to: 1) nontolerated joint stress loading due to a change in the lever arm length of the amputated phalanx, or 2) inadequate cartilage nutrition owing to lack of stress applied to this joint. Maintaining digital length must be rethought with emphasis placed on painless function. Considering the losses to these patients in terms of time, employment, and money, a distal remnant measuring 4 mm or less should be excised, regardless of the digit, at the time of the injury.

Braun M, Horton RC, Snelling CF. Fingertip amputation: review of 100 digits. Can J Surg. 1985 Jan;28(1):72-5.

Evaluation of the functional results and complications of 100 fingertip amputations revealed no difference between the two most commonly used repairs; 52 injuries were treated by primary closure with residual viable skin flaps and 27 by split-thickness skin grafting. No decline in unfavorable functional results was found when patients evaluated 6 weeks after injury were compared to patients evaluated 42 weeks after injury, suggesting that delaying the patient's return to full activity by prolonging rehabilitation is unlikely to yield much improvement. Shortening the nerves in proximal amputations closed by residual flaps did not decrease nerve irritation. Resection of bone produced a mobile amputation-stump tip. While the mean time off work or return to full activity following skin grafting was 6 days less than it was after primary closure, the difference was not significant.

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 KNOWLEDGBASE**
- 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) Fessler PR Fingertip Injuries: Evaluation and Treatment. J Am Acad Orthop Surg. 1996 Jan;4(1):84-92.

Gross SC, Watson HK Revision of painful distal tip amputations. Orthopedics. 1989 Dec;12(12):1561-4.

Braun M, Horton RC, Snelling CF. Fingertip amputation: review of 100 digits. Can J Surg. 1985 Jan;28(1):72-5.
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)