



3250 W. Pleasant Run, Suite 125 Lancaster, TX 75146-1069
Ph 972-825-7231 Fax 972-274-9022

Notice of Independent Review Decision

DATE OF REVIEW: 11-18-2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of:

Left Index Finger Transfer Hands defect < 10 sq cm
Surgical Preparation Hand first 100 sq cm
Manipulation of Joint Under Anesthesia
Capsulectomy/Capsulotomy
LOS 1day
14040, 15004, 26340, 26525, 99231

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 board certified in Orthopedic Surgery. This reviewer has been practicing 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:

Left Index Finger Transfer Hands defect < 10 sq cm

Surgical Preparation Hand first 100 sq cm
Manipulation of Joint Under Anesthesia
LOS 1day
14040, 15004, 26340, 99231

The reviewer disagrees with the previous adverse determination regarding the:

Capsulectomy/Capsulotomy - 26525

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

Records of the treating provider (a Dr.) were reviewed. The cut his hand while working . Multiple joints of the left index finger and the left thumb were injured. An STSG/flap was provided to the radial aspect of the affected portion of the index finger/hand, along with nerve repair, as of xx/xx/xx. Residual scarring was noted, including at the thumb-index web space and index MP joint. There was reduced functionality of the hand noted as a residual injury

sequelae, despite therapy. As of xx/xx/xx, a bulky flap, 75 degree contracted index PIP, contracted web space (thumb-index) and reduced digit functionality were noted. Hand therapy records from the Fall, 2011 were reviewed. Denial letters denote the lack of therapy and/or only support flap debulking, PIP and web space contracture release.

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

Surgical intervention as requested is inconsistent with the recent records. The claimant has an indication for only surgical debulking of the proliferative flap/scar, along with release of the contracted web space and PIP joint of the affected index finger. These procedures would be designed to improve functionality. The proposed procedures are not medically necessary. Soft tissue transfer and surgical preparation for same is not medically necessary due to the *lack of residual defect of soft tissue, and, lack of expectation for the development of same.* Joint manipulation is specifically “not recommended” by guidelines. A capsulotomy is medically necessary for contracture release purposes, despite the lack of guidelines. An overnight stay is not medically necessary as the only necessary proposed procedure (capsulotomy) warrants outpatient surgery only.

Reference: ODG Hand/Wrist

Wound dressings

Recommended as indicated below. Recommend the following combinations: for chronic wounds, (1) debridement stage, hydrogels; (2) granulation stage, foam and low-adherence dressings; and (3) epithelialization stage, hydrocolloid and low-adherence dressings; and for the epithelialization..

Manipulation under anesthesia	Not recommended for the wrist, hand or fingers. There are no high quality studies published in peer-reviewed journals accepted into Medline.
Hospital length of stay (LOS)	Recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications.

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