

# MEDR



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## Notice of Independent Review Decision

**AMENDED REPORT  
1/11/2011**

**DATE OF REVIEW:** 01/07/11

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of a 99214 office visit (est 25 min).

**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 prospective medical necessity of a 99214 office visit (est 25 min).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

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

The claimant was noted to have undergone a trigger finger release and a post-operative follow up visit, the later on 2/8/10. The claimant had full motion on that date, was “doing well” without tenderness and was advised further follow-up only as needed. Prior post-up visits included a 12/28/09 dated injection notation. The 10/22/09 dated operative note was reviewed. The 11/09 dated post op note included an evaluation and stitch removal, notations of “doing well” and only slight sensitivity, and a prescription for range of motion promoting exercises.

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

The ODG-Hand Chapter notes the following regarding office visits. Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a “flag” to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. *Note:* The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of “virtual visits” compared with inpatient visits; however the value of patient/doctor interventions has not been questioned.

Percutaneous release (of the trigger finger and/or trigger thumb) is recommended where symptoms persist. Trigger finger is a condition in which the finger becomes locked in a bent position because of an inflamed and swollen tendon. In cases where symptoms persist after steroid injection, surgery may be recommended. However, the risk of troublesome

complications, even after this minor operation, should be born in mind. One hundred and eighty patients with 240 trigger digits were treated by percutaneous release using a 'lift-cut' technique. All patients were reviewed at 3 months following release. Overall, 94% achieved an excellent or good result. Ten patients experienced

recurrent symptoms and required a subsequent open release. There was no clinical evidence of digital nerve or flexor tendon injury. According to one study, percutaneous release with steroid injection of trigger thumbs is a cheap, safe and effective procedure with a low rate of complications. Percutaneous release with steroid injection produced satisfactory long-term results in 91% of cases whereas steroid injection alone produced satisfactory results in 47% of cases. Percutaneous trigger thumb release combined with steroid injection has a higher success rate than that of steroid injection alone. Surgical release of the A1 pulley for treatment of trigger finger normally produces excellent results. However, in patients with long-standing disease, there may be a persistent fixed flexion deformity of the proximal interphalangeal joint due to a degenerative thickening of the flexor tendons. Treatment by resection of the ulnar slip of flexor digitorum superficialis tendon is indicated for patients with loss passive extension in the proximal interphalangeal joint and a long history of triggering. One study concluded that surgical outcome for trigger finger was poorer than that for trigger thumb, partly due to flexion contracture of the PIP joint.

The reviewer notes that without any subjective or objective abnormalities on 2/8/10, an additional 99214 office visit is not medically reasonably required. There has been no evidence of an ongoing significant medical condition that would warrant such follow-up evaluation. Clinical guidelines do not therefore support an office visit such as 99214 on an upcoming prospective basis.

**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)**