



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 7/22/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of DME hand CPM rental 1-3 months (E0936 softgoods PNR).

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. The 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 DME hand CPM rental 1-3 months (E0936 softgoods PNR).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: Encounter Summary Notes – 4/20/11-6/15/11; Certified Hand Therapy Center notes – 4/20/11-5/31/11, and Progress Notes – 4/20/11-5/31/11.

Records reviewed from Healthcare: Denial letters – 4/27/11-5/23/11; Certified Hand Therapy Center Pre-auth requests – 4/20/11 & 5/18/11, Patient Face Sheet – 4/20/11, Office Notes – 4/20/11, Progress Notes – 4/20/11, Scripts – 4/20/11 & 5/18/11; Utilization Review Referral – 4/20/11; Hand Center Encounter Summary – 4/20/11; MD Clinical Encounter Summaries – 4/20/11, Prescription & Letter of medical necessity – 4/20/11; Lantz Medical pre-auth request – 4/25/11, Vector 1 pamphlet, Appeal Request – 5/11/11; and MD Office Note – 4/28/11.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The Attending Physicians records were reviewed. This included the record in which the claimant was evaluated for a wrist scaphoid fracture. Diagnoses included scaphoid non-union with advanced collapse, along with arthritis and possible early complex regional pain syndrome. Treatments included medications, splinting, injections and therapy. Therapy records were reviewed. On 4/8/11, therapy records denoted -8 degrees of extension and 18 degrees of flexion, among other motion details. On 4/20/11, additional therapy was prescribed. On 5/31/11, therapy records documented markedly abnormal motion at the wrist, including -3 degrees of extension, flexion of 20 degrees, limited ulnar deviation, radial deviation, supination and pronation. Denial letters discussed motion improvement (or lack thereof) not having been documented, along with the lack of imaging films corroborating findings.

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

The claimant has a documented lack of improvement in motion in the affected wrist. The claimant has clearly plateaued in therapy. The claimant has an arthritic and painful wrist that has not adequately responded to therapy, medications or injection treatment. However, although CPM has been utilized and recommended as applicable to promote motion preservation after “flexor tendon repair in the hand” as noted below, long term outcome studies have not been documented. Efficacy and/or safety have not been determined in overcoming challenged wrists (especially those with diagnoses of non-union (x-rays not submitted), arthrosis, collapse and complex regional pain syndrome, such as in this case.

ODG/Wrist Chapter:

Continuous passive motion (CPM)- Recommended. Controlled mobilization regimens are widely employed in rehabilitation after flexor tendon repair in the hand. One trial compared continuous passive motion (CPM) with controlled intermittent passive motion (CIPM) and found a significant difference in mean active motion favoring CPM. A prospective multicenter clinical study found that greater durations of daily passive-motion rehabilitation after flexor tendon repair leads to improved tendon gliding without greater risk of injury.

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)