



505 N. Sam Houston Pkwy E., Suite 200  
Houston, TX 77060

Phone: 832-260-0439

Fax: 832-448-9314

Notice of Independent Review Decision

**DATE OF REVIEW:** APRIL 16, 2011 **AMENDED:** APRIL 20, 2011

**IRO CASE #:**

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

Occupational Therapy 3x4 weeks left long finger

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

This physician is a Board Certified Physical Medicine and Rehabilitation with 15 years experience.

**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)

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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

On December 29, 2010 there is a post operative clinic note by MD which states the date of injury was xx/xx/xx. Mechanism of injury left hand crushed injury with laceration, left long and index fingers by a falling sheet metal approx. 1000lbs. The note states that the claimant states he is doing well and having random pain in the index and long fingers. He has completed his oral antibiotic medication and presents with dressing on his fingers. Quantitative tests: musculoskeletal system calibrated strength measurement. Left thumb: 3.61; index (blank); long (blank); ring: 3.61; small: 3.61. Left ROM: Elbow flexion 135 extension 0; forearm supination 70 pronation 70; wrist flexion 60 extension 60; Thumb CMC, Thumb MP, Thumb IP, MP index, MP long, MP ring, MP small, PIP index, PIP long, PIP ring, PIP small, DIP index, DIP long, DIP ring, DIP small are blank. Diagnosis left finger multiple crush /contusion; left multiple tendon laceration, digit; left long wound finger amputation. The plan states claimant is to begin therapy as soon as possible to attend 3 visits per week for 4 weeks focus on MP,

PIP, DIP/IP, using AROM, edema control with compression wraps. Comments states both FDS and FDP were fully lacerated and repaired to P2, claimant can do pure active and assisted only, NO resistance loading and no high force passive stretch into extension both of those will rupture his repairs. Activity restrictions start date: 12/29/2010 End date undetermined.

On January 12, 2011 there is a post operative clinic note by MD which states the date of injury was xx/xx/xx. Mechanism of injury left hand crushed injury with laceration, left long and index fingers by a falling sheet metal approx. 1000lbs. The note states that the claimant states some stiffness in the index and long fingers. Quantitative tests: musculoskeletal system calibrated strength measurement. Left thumb: 3.61; index (blank); long (blank); ring: 3.61; small: 3.61. Left ROM: Elbow flexion 135 extension 0; forearm supination 70 pronation 70; wrist flexion 60 extension 60; Thumb CMC Palmar A: 40 Radial abduction 50, Thumb MP flexion 50 extension 0, Thumb IP flexion 50 extension 0, MP index flexion 70 extension 0, MP long flexion 70 extension 0, MP ring flexion 70 extension 0, MP small flexion 70 extension 0, PIP index flexion 80 extension 0, PIP long flexion 60 extension 0, PIP ring flexion 80 extension 0, PIP small flexion 80 extension 0, DIP index flexion 30 extension 0, DIP long blank, DIP ring flexion 30 extension 0, DIP small flexion 30 extension 0. X-ray results 12/29/10 left side elbow 3 views long findings positive for DIP disarticulation of long. Diagnosis left finger multiple crush /contusion; left multiple tendon laceration, digit; left long wound finger amputation. The plan states claimant is to begin therapy as soon as possible to attend 3 visits per week for 4 weeks focus on MP, PIP, DIP/IP, using AROM, edema control with compression wraps. Comments states both FDS and FDP were fully lacerated and repaired to P2, claimant can do pure active and assisted only, NO resistance loading and NO high force passive stretch into extensions both of those will rupture his repairs. Surgeon's comments states reviewed the proper gentle active pull and then assisted motion for additional resistance he feels with caution about potential still for rupture.

On February 2, 2011 there is a post operative clinic note by MD which states the date of injury was xx/xx/xx. Mechanism of injury left hand crushed injury with laceration, left long and index fingers by a falling sheet metal approx. 1000lbs. The note states that the claimant states some pain and stiffness in the index and long fingers. Quantitative tests: musculoskeletal system calibrated strength measurement. Left thumb: 3.61; index (blank); long (blank); ring: 3.61; small: 3.61. Left ROM: Elbow flexion 135 extension 0; forearm supination 70 pronation 70; wrist flexion 60 extension 60; Thumb CMC Palmar A: 40 Radial abduction 50, Thumb MP flexion 50 extension 0, Thumb IP flexion 50 extension 0, MP index flexion 70 extension 0, MP long flexion 70 extension 0, MP ring flexion 70 extension 0, MP small flexion 70 extension 0, PIP index flexion 80 extension 0, PIP long flexion 60 extension 0, PIP ring flexion 80 extension 0, PIP small flexion 80 extension 0, DIP index flexion 30 extension 0, DIP long blank, DIP ring flexion 30 extension 0, DIP small flexion 30 extension 0. X-ray results 12/29/10 left side elbow 3 views long findings positive for DIP disarticulation of long. Diagnosis left finger multiple crush /contusion; left multiple tendon laceration, digit; left long wound finger amputation. The plan states claimant is to begin therapy as soon

as possible to attend 3 visits per week for 4 weeks focus on MP, PIP, DIP/IP, using AROM, edema control with compression wraps. Comments states can now make a full active pull of the flexors as they will be sufficiently healed.

On February 2, 2011 a therapy note from Sports Medicine for Hand/Wrist/Elbow/Hand Therapy Re-eval received by OT. ROM for left hand states MP (A) index 0-80; middle 0-80; MP (P) Index 0-90, middle 0-95; PIP (A) Index 0-80, middle 0-95; PIP (A) Index 0-80; middle 0-60; PIP (P) Index 0-90 middle 0-85; DIP (A) index 0-40, middle amputated; DIP (P) index 0-70, middle amputated; TAM Index 200, Middle 140. Left thumb MP 0-75; IP 0-60; R-abd 0-70, P-abd 0-60; opp full. Other sate L 2<sup>nd</sup>, 3<sup>rd</sup>-3.61-diminished light touch, 3<sup>rd</sup> increased from 4.3, L 3<sup>rd</sup> 7.3 cm/decreased from 8.0 cm, middle phalanx 7.0 (7.2 cm) Left 3<sup>rd</sup> PIP 7.6 cm; right 3<sup>rd</sup> 7.0cm. Objective problem list included decreased ROM, soft tissue dysfunction, scar adhesions, palpation tenderness, decreased ADL skills, decreased flexibility, decrease sensibility, joint hypomobility, and edema.

On February 23, 2011 there is a post operative clinic note by MD which states the date of injury was xx/xx/xx. Mechanism of injury left hand crushed injury with laceration, left long and index fingers by a falling sheet metal approx. 1000lbs. The note states that the claimant states some pain and stiffness in the index and long fingers. Quantitative tests: musculoskeletal system calibrated strength measurement. Left thumb: 3.61; index (blank); long (blank); ring: 3.61; small: 3.61. Left ROM: Elbow flexion 135 extension 0; forearm supination 70 pronation 70; wrist flexion 60 extension 60; Thumb CMC Palmar A: 40 Radial abduction 50, Thumb MP flexion 50 extension 0, Thumb IP flexion 50 extension 0, MP index flexion 70 extension 0, MP long flexion 75 extension 0, MP ring flexion 80 extension 0, MP small flexion 80 extension 0, PIP index flexion 80 extension 0, PIP long flexion 60 extension 0, PIP ring flexion 80 extension 0, PIP small flexion 90 extension 0, DIP index flexion 30 extension 0, DIP long blank, DIP ring flexion 30 extension 0, DIP small flexion 30 extension 0. X-ray results 12/29/10 left side elbow 3 views long findings positive for DIP disarticulation of long. Diagnosis left finger multiple crush /contusion; left multiple tendon laceration, digit; left long wound finger amputation. The plan states claimant is to begin therapy as soon as possible to attend 3 visits per week for 4 weeks focus on MP, PIP, DIP/IP, using AROM, edema control with compression wraps. Comments states can now make a full active pull of the flexors as they will be sufficiently healed.

On February 23, 2011 there is a Therapy Prescription by, MD state begin therapy as soon as possible, to attend 3 visits per week for 4 weeks. Focus on target strengthening no motion limit.

On February 8, 2011 OT Therapy from Sports Medicine note states cont. to make steady progress towards current goals. L IF>L MF. Intrinsic stretch more limited than composite stretch.

On February 9, 2011 OT Therapy from Sports Medicine note states increased AROM of Left IF, LF from last session. Left LF remains more limited, increased ability to hold flexion of digits with place and hold exs.

On February 10, 2011 OT Therapy from Sports Medicine note states cont. to progress with a/pROM of Left IF, LF, pt reassessed please see Re- eval for full report; decreased edema.

On February 22, 2011 OT Therapy from Sports Medicine note states cont edema. But increased AROM Left IF, LF at end of tx. Left LF remains stiffer and more edematous increased overall left grip (0) functional use. The scar tissue is gradually softening.

On February 23, 2011 OT Therapy from Sports Medicine note states began on light strengthening with 0 problems; has difficulty with Left LF with putty secondary to amputation; fatigued quickly; has continued a/p ROM of Left IF, LF at end of tx.

On February 25, 2011 OT Therapy from Sports Medicine note states cont. to progress with increased AROM left IF>L MR; continues to have edema in both digits; provided with blue putty to begin strengthening at home. PROM increased at end of treatment in and intrinsic flexion.

On March 7, 2011 there is a non certification notification from The to MD. The notification states in the history the claimant is a male who reposted a work injury on xx/xx/xx. Mechanism of injury: Machinist part fell on hand. The diagnosis provided is: Finger crushing injury, open wound finer; finer amputation. There is a request of 12 sessions. The patient has completed 18 supervised rehab sessions to date. Only 2/10/11 rehab assessment was provided for review. Long finger digit active range of motion is 0-80 MP; 0-60 PIP; DIP amputated. There is a note of decreased sensation. OT re-assessment of 3/1/11 reviewed. There is documentation of increasing ROM. Left long finger remains stiffer; no AROM measurements are provided for review. No MD notes are provided for review. Criteria: ODG hand Chapter Fracture of one of more phalanges of hand (fingers). Conclusion: Recommend adverse determination. The patient has completed 18 supervised rehab sessions to date. There is documented progress. Recent digit AROM values are not submitted for review. Additional supervised rehab is outside of ODG recommendations. Barrier to an independent HEP are not documented.

On March 16, 2011 there is a post operative clinic note by MD Locum Tenens coverage for MD which states the date of injury was xx/xx/xx. Mechanism of injury left hand crushed injury with laceration, left long and index fingers by a falling sheet metal approx. 1000lbs. The note states that the claimant states having pain and swelling in the index and long fingers. Quantitative tests: musculoskeletal system calibrated strength measurement. Left thumb: 3.61; index (blank); long (blank); ring: 3.61; small: 3.61. Left ROM: Elbow flexion 135 extension 0; forearm supination 70 pronation 70; wrist flexion 60 extension 60;

Thumb CMC Palmar A: 40 Radial abduction 50, Thumb MP flexion 50 extension 0, Thumb IP flexion 50 extension 0, MP index flexion 70 extension 0, MP long flexion 75 extension 0, MP ring flexion 80 extension 0, MP small flexion 80 extension 0, PIP index flexion 80 extension 0, PIP long flexion 60 extension 0, PIP ring flexion 90 extension 0, PIP small flexion 90 extension 0, DIP index flexion 30 extension 0, DIP long blank, DIP ring flexion 30 extension 0, DIP small flexion 30 extension 0. X-ray results 12/29/10 left side elbow 3 views long findings positive for DIP disarticulation of long. Diagnosis left finger multiple crush /contusion; left multiple tendon laceration, digit; left long wound finger amputation. The plan states claimant is to begin therapy as soon as possible to attend 3 visits per week for 4 weeks focus on MP, PIP, DIP/IP, using AROM, edema control with compression wraps. Comments state claimant should continue therapy and increase his strengthening.

On March 17, 2011 there is a reconsideration denial notification from The MD. The notification states this "Peer clinical reviewer has upheld the original non-certification determination". The reason for non-certification states: At your request I have reviewed the medical records pertain to the above-captioned claimant, at which time a preauthorization review was performed for medical necessity. History states the claimant is a xx yo male claimant sustained a crush injury to his left hand on xx/xx/xx when a machine part fell on his hand. Therapy records of February 2011 noted the claimant diagnosed with multiple crush/contusion, wound, tendon laceration and finger amputation. Procedures included wound closure, amputation and tendon repair. The claimant was noted to be making slow steady progress toward goals. Range of motion in the left long, ring and small fingers was noted to be decreased with associated pain, stiffness, and swelling. Additional therapy was requested. Criteria noted were ODG Hand Chapter Disability Guidelines Treatment in Worker's Comp. 16<sup>th</sup> edition, 2011 Updates Forearm, Wrist and Hand. The conclusion states "efforts to contact Dr. have been unsuccessful. As such this must be answered based on records alone. The gest guideline to use for assessment of this case would be the open wound of the finer or hand where post surgical management would warrant 24 visits over 16 weeks to date, 12 additional visits have been requested. This would go beyond the recommended number of visits in the ODG Guidelines; as such the ODG Guidelines would not be satisfied for medical necessity regarding the proposed therapy. The treating physician is not available to seek a modification for an additional 6 visits.

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

The claimant is a and was injured when a part fell on hand.

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

Decision to deny additional therapy is upheld upon. ODG Hand Chapter recommends 18 visits over 6 weeks for medical treatment of finger amputation (in this case the left long finger at the DIP without reimplantation) and 24 visits over 16 weeks for post-surgical tendon repair (in this case FDS and FDP to P2).

Records indicate claimant has had 18 OT visits with improvement in AROM and strength and HEP. Request for additional therapy exceeds recommended number of OT visits per the ODG.

**ODG Physical/Occupational Therapy Guidelines –**

Allow for fading of treatment frequency (from up to 3 visits or more per week to 1 or less), plus active self-directed home PT. More visits may be necessary when grip strength is a problem, even if range of motion is improved. Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#).

**Open wound of finger or hand (ICD9 883):**

9 visits over 8 weeks. See also [Early mobilization](#) (for tendon injuries).

Post-surgical treatment/tendon repair: 24 visits over 16 weeks

**Pain in joint (ICD9 719.4):**

9 visits over 8 weeks

**Amputation of thumb; finger (ICD9 885; 886):**

Medical treatment: 18 visits over 6 weeks

Post-replantation surgery: 36 visits over 12 weeks

**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)