

Clear Resolutions Inc.

An Independent Review Organization
6800 W. Gate Blvd., #132-323
Austin, TX 78745
Phone: (512) 879-6370
Fax: (512) 519-7316
Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/20/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

outpatient right thumb exploration volar plate/repair volar plate/thumb mcp joint

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

M.D., Board Certified General Surgery; Fellowship trained Orthopedic Hand and Upper Extremity Surgery

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 medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that medical necessity exists for the proposed outpatient right thumb exploration volar plate/repair volar plate/thumb mcp joint.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Notice of utilization review findings 05/23/12
Notice of utilization review findings 06/15/12
Preauthorization request 05/18/12
Office notes
Second opinion
MRI right thumb 03/10/11
Preauthorization appeal request 06/07/12
Progress notes
Electrodiagnostic testing 05/16/11
Designated doctor's evaluation
Chiropractic progress notes
Employee's report of injury
Notice of disputed issues and refusal to pay benefits 05/11/11 and 05/29/12
Functional capacity evaluation 05/24/11, 12/19/11, 01/27/12
Manual muscle testing and range of motion 06/10/11-05/14/12
Physical therapy notes 10/26/10-11/05/10
Progress notes
Orthopedic evaluation

EMG/NCV 05/16/11

Initial psychological evaluation 05/14/12

Individual psychotherapy progress note 1 of 6 sessions 06/14/12

Peer review 06/28/11

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female. She was working. The patient continued to complain of right thumb pain at level of metacarpophalangeal joint. MRI of her right thumb on 03/10/11 revealed hyperintensity of soft tissue of thenar aspect of hand that reflect contusion; mild hyperintensity in homogeneity of fibers of volar plate may reflect partial tear of structure, but it is not completely torn or retracted; no fracture or collateral ligament injury; small flexor pollicis longus tendon sheath fusion. She has been treated with medications, physical therapy, cortisone injection, brace, and individual psychotherapy. The claimant was seen with chief complaint of sprained hand. It was noted the claimant is now 18 months post injury and still has a lot of complaints of pain. Repeat MRI has been denied. Physical examination reported pain over the thumb MP. There are no skin changes or rashes. The joint is stiff. The opposite thumb has typical plate. There is no crepitus. It is still a little swollen around metacarpophalangeal joint. Pinwheel and pinprick are intact. There is good capillary refill. No radiographs were performed on this date. The claimant was recommended to explore joint surgically, repair volar plate if it is not healed.

A request for outpatient right thumb exploration of volar plate / repair volar plate / thumb MCP joint was not authorized per utilization review dated 05/23/12 noting volar plate repairs are typically performed on digits with chronic instability, deformity or locking of joint despite conservative treatment. The claimant's main complaints are of pain, swelling, deficits and active range of motion of all digits (latter not confirmed by physical examination). There was no evidence of instability, locking or deformity documented. There was insufficient clinical documentation to support medical necessity of this request.

A reconsideration request for outpatient right thumb exploration volar plate / repair volar plate / thumb MCP joint was non-authorized and original decision upheld per utilization review dated 06/15/12. It was noted there was no instability documented clinically. There are no imaging studies supporting full tear. Exploration 7 months after injury is not supported by current literature.

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

The claimant is noted to have sustained an injury. MRI right thumb on 03/10/11 revealed findings that may reflect partial tear of the volar plate, but it was noted as not completely torn or retracted. The claimant was treated conservatively with medications, physical therapy, cortisone injections, bracing and individual psychotherapy without significant improvement. The patient went through therapy but continues to complain of pain and weakness and difficulty with use of right thumb. Request for repeat MRI to see if there has been increased tearing of volar plate has been denied. Per designated doctor's evaluation on 01/27/12 it was noted the claimant is not at maximum medical improvement and will most likely get surgery to repair her thumb despite not getting repeat MRI requested. It was noted in the records that she can perform very little with her right hand, which is her dominant hand. Given the current clinical data, and noting the failure of conservative care and ongoing functional limitations, it is the opinion of the reviewer that medical necessity exists for the proposed outpatient right thumb exploration volar plate/repair volar plate/thumb mcp joint.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ACOEM-AMERICA 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)