

**AccuReview**  
An Independent Review Organization  
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Notice of Independent Review Decision

**DATE OF REVIEW:** December 20, 2011

**IRO CASE #:**

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

Post Op Therapy for trigger finger release x 24 visits 97140, 97110, 97012, 97035

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

This physician is Board Certified Family Medicine with over 13 years of 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:**

10-20-10: Medical Report by  
11-18-10: Medical Report by  
12-17-10: Medical Report by  
12-19-10: Physical Performance Evaluation by  
02-18-11: Medical Report by  
03-18-11: Medical Report by  
03-28-11: Medical Report by  
04-15-11: Medical Report by

04-30-11: MRI of the left interpreted by  
05-09-11: Medical Report by  
05-18-11: Medical Report by 06-17-11: Medical Report by  
06-17-11: Medical Report by  
07-15-11: Medical Report by  
07-22-11: Medical Report by  
08-15-11: Medical Report by  
09-30-11: Medical Report by  
09-30-11: Medical Report by  
10-28-11: Medical Report by  
11-01-11: UR by  
11-16-11: UR by  
11-23-11: Medical Report by

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

10-20-10: Medical Report by. It was noted the claimant's left second finger had been triggering in the extended position. On physical examination she was not acutely tender to palpation about the left second finger and did not necessarily have any triggering in extension.

12-17-10: Medical Report by. It was noted that that the problem of triggering of the left second finger mainly occurred while typing. A physical performance evaluation where typing would be included was recommended.

12-29-10: Physical Performance Evaluation by. It was noted that she was able to type 8 minutes before the finger did lock and then was able to type an additional period of time up to the 40 minute mark where the finger locked and the pain was too great to continue.

02-18-11: Medical Report by. The claimant reported a couple of occasions were her when locked up during extension while typing. was not able to reproduce the triggering on examination. She was referred to for an orthopedic hand evaluation.

03-28-11: Medical Report by. On physical examination the claimant had tenderness over a nodule on the FDS to the index finger proximal to the A1 pulley. She had pain with terminal extension. There was no frank locking with flexion. Neurovascularly she was intact. A1 pulley was minimally tender; again, tenderness was proximal. There appeared to be a soft tissue mass on the FDS. diagnosed a left index finger FDS soft tissue mass, probable ganglion. A MRI of the left hand was recommended.

04-30-11: MRI of the left hand interpreted by Impression: 1. Skin marker along the volar aspect of the second MCP joint. Mild tenosynovitis deep to skin marker. No distinct mass. 2. Mild sprain or chronic injury of the radial collateral ligament of the second MCP joint. 3. Small effusion in the first, second, and third MCP joints. 4. No fracture.

05-09-11: Medical Report by. opined that the MRI results were consistent with tenosynovitis. He performed an injection of her left index finger with 40 mg of Depo Medrol.

05-18-11: Medical Report by. It was noted she did not notice any change in locking symptoms from the injection of the flexor synovial sheath, but did have some numbness associated with the injection distal to the metacarpophalangeal joint. She was referred back to for evaluation as to whether she was a candidate for an injection in the extensor synovial sheaths.

06-17-11: Medical Report by. It was noted that she reported that the injection did help; however, she still had pain. She also complained of numbness on the ulnar aspect of the index finger. He injected her index flexor tendon sheath with 40 mg of Depo Medrol.

07-22-11: Medical Report by. On physical examination there was tenderness of the A1 pulley with clicking in flexion and extension. There was also a small proximal cyst to the A1 pulley. recommended a left index trigger finger release.

09-30-11: Medical Report by. It was noted she was post left second trigger finger release with eight days ago. She had a flexor tendon release. She reported that the second night after surgery her finger locked in extension, and has since locked an additional two times. She also had complaints of some numbness in the left second and third fingers. recommended postoperative therapy and rehab.

09-30-11: Medical Report by. It was noted she still had complaints of numbness to the index and long finger on both the radial and ulnar aspects. She had initially reported numbness including the thumb. Sutures were removed and she had full motion of her index finger.

10-28-11: Medical Report by. It was reported that she had been having episodes of triggering in the left second finger just as she was experiencing prior to the surgery itself. She had noticed that if she had her finger primarily extended and then presses it into a pressure situation, as though she was flexing the finger if she were holding a phone etc., that sometimes with these activities the triggering would occur. She also had numbness in the left second and third finger and complained of scar tissue and tenderness associated with the surgical site. On physical examination he was not able to reproduce the triggering, but she did have notable scar tissue about the surgical site. She had very tight bands of easily palpable scar tissue about the surgical site. She had decreased sensation in the left second and third finger to touch versus the right. He recommended therapy.

11-01-11: UR by. Reason for Denial: The patient is now 6 weeks out from her surgery....no mention is made in the clinical reports regarding how much (if any) therapy the patient has received since surgery. Current nationally accepted clinical practice guidelines as published in the Official Disability Guidelines –Treatment in

Workers' Compensation 2011 Online Edition support up to 9 sessions of formally structured and medically supervised physical Therapy following surgical release of a trigger finger.

11-16-11: UR by. Reason for Denial: ODG provides best practice physical therapy guidelines of up to 9 physical medicine visits over 8 weeks for post-surgical treatment of trigger finger. In this case, there is no documentation of previous post-operative physical therapy or occupation therapy care to date. The claimant complains of intermittent triggering and numbness, but there are no objective or functional deficits outlined in the submitted documentation. Without documented deficits and clear clinical history outlining physical medicine care to date, medical necessity of physical therapy cannot be established.

11-23-11: Medical Report by. On physical examination there was notable scar tissue at the surgical site which seemed very firm and well delineated. He found he could reproduce the same findings that had with both part of the Tinel's resulting in first through third digit symptoms in the left hand and a positive tapping over the scar tissue resulting in significant pain into the third more than second finger of the left hand. It was reported recommended EMG/NCV and agreed. He also continued to recommend therapy.

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

The previous decisions are partially overturned. Based on review of medical records, the request for physical therapy and/or occupational therapy is reasonable. However, the number of visits requested exceeds the recommendations as outlined in the ODG guides. The ODG only recommends 9 visits over 8 weeks for post operative therapy for trigger finger. This would be reasonable. Therefore, my recommendation partially overturns the previous decision.

#### **ODG:**

Recommended. Positive (limited evidence). See also specific physical therapy modalities by name. Also used after surgery and amputation. Early physical therapy, without immobilization, may be sufficient for some types of undisplaced fractures. It is unclear whether operative intervention, even for specific fracture types, will produce consistently better long-term outcomes. There was some evidence that 'immediate' physical therapy, without routine immobilization, compared with that delayed until after three weeks immobilization resulted in less pain and both faster and potentially better recovery in patients with undisplaced two-part fractures. Similarly, there was evidence that mobilization at one week instead of three weeks alleviated pain in the short term without compromising long-term outcome. ([Handoll-Cochrane, 2003](#)) ([Handoll2-Cochrane, 2003](#)) During immobilization, there was weak evidence of improved hand function in the short term, but not in the longer term, for early occupational therapy, and of a lack of differences in outcome between supervised and unsupervised exercises. Post-immobilization, there was weak evidence of a lack of clinically significant differences in outcome in patients receiving formal rehabilitation therapy, passive mobilization or whirlpool immersion compared with no intervention. There was weak evidence of a short-term benefit of continuous passive motion (post external fixation), intermittent pneumatic compression and ultrasound. There was weak evidence of better short-term hand function in patients given physical therapy than in those given instructions for home exercises by a surgeon. ([Handoll-Cochrane, 2002](#)) ([Handoll-Cochrane, 2006](#))

Hand function significantly improved in patients with rheumatoid arthritis after completion of a course of occupational therapy ( $p < 0.05$ ). ([Rapoliene, 2006](#))

*Active Treatment versus Passive Modalities:* See the [Low Back Chapter](#) for more information. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including Neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530).

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](#).

**Fracture of carpal bone (wrist)** (ICD9 814):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 16 visits over 10 weeks

**Fracture of metacarpal bone (hand)** (ICD9 815):

Medical treatment: 9 visits over 3 weeks

Post-surgical treatment: 16 visits over 10 weeks

**Fracture of one or more phalanges of hand (fingers)** (ICD9 816):

Minor, 8 visits over 5 weeks

Post-surgical treatment: Complicated, 16 visits over 10 weeks

**Fracture of radius/ulna (forearm)** (ICD9 813):

Medical treatment: 16 visits over 8 weeks

Post-surgical treatment: 16 visits over 8 weeks

**Dislocation of wrist** (ICD9 833):

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment (TFCC reconstruction): 16 visits over 10 weeks

**Dislocation of finger** (ICD9 834):

9 visits over 8 weeks

Post-surgical treatment: 16 visits over 10 weeks

**Trigger finger** (ICD9 727.03):

Post-surgical treatment: 9 visits over 8 weeks

**Radial styloid tenosynovitis (de Quervain's)** (ICD9 727.04):

Medical treatment: 12 visits over 8 weeks

Post-surgical treatment: 14 visits over 12 weeks

**Synovitis and tenosynovitis** (ICD9 727.0):

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment: 14 visits over 12 weeks

**Mallet finger** (ICD9 736.1)

16 visits over 8 weeks

**Contracture of palmar fascia (Dupuytren's)** (ICD9 728.6):

Post-surgical treatment: 12 visits over 8 weeks

**Ganglion and cyst of synovium, tendon, and bursa** (ICD9 727.4):

Post-surgical treatment: 18 visits over 6 weeks

**Ulnar nerve entrapment/Cubital tunnel syndrome** (ICD9 354.2):

Medical treatment: 14 visits over 6 weeks

Post-surgical treatment: 20 visits over 10 weeks

**Sprains and strains of wrist and hand** (ICD9 842):

9 visits over 8 weeks

**Sprains and strains of elbow and forearm** (ICD9 841):

Medical treatment: 9 visits over 8 weeks

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

*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

**Arthropathy, unspecified** (ICD9 716.9):

Post-surgical treatment, arthroplasty/fusion, wrist/finger: 24 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*

**Amputation of hand** (ICD9 887):

Post-replantation surgery: 48 visits over 26 weeks

**Work conditioning** (See also [Procedure Summary](#) entry):

12 visits over 8 weeks

**Carpal tunnel syndrome** (ICD9 354.0):

Medical treatment: 1-3 visits over 3-5 weeks

Post-surgical treatment (endoscopic): 3-8 visits over 3-5 weeks

Post-surgical treatment (open): 3-8 visits over 3-5 weeks

*Crushing injury of hand/finger (ICD9 927.2 & 927.3):*

9 visits over 8 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)**