

# Icon Medical Solutions, Inc.

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## Notice of Independent Review Decision

**DATE:** September 5, 2012

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

Occupational Therapy 2 x 4 weeks – Left Hand 97110, 97530, 97022, 97010

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

This physician is Board Certified by the American Board of Occupational Medicine with over 34 years of experience.

### **REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

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

The claimant is a male who sustained a work-related injury to the left hand on xx/xx/xx. He is status post middle finger amputation and ORIF of the 2<sup>nd</sup>, 4<sup>th</sup>, and 5<sup>th</sup> digits. He has attended 44 sessions of postoperative therapy.

09/16/11: Operative Report. POSTOPERATIVE DIAGNOSIS: Blast injury to the left hand and left lower extremity. PROCEDURE: Left lower extremity exploration, incision, irrigation, debridement, anterior lateral fasciotomy and repair of tibialis anterior muscle. Left hand incision, irrigation, and debridement of skin, muscle, fascia, and bone. Exploration of penetrating wounds. Ray amputation, left long finger. ORIF CMC dislocations, second, third, fourth, and fifth digits. ORIF second MCP joint fracture dislocation.

09/16/11: Surgical Pathology Report. DIAGNOSIS: Finger, left, long, amputation (secondary to crush injury): Skin and soft tissue with extensive hemorrhagic disruption, consistent with clinic history of crush injury.

09/28/11: The claimant was evaluated for initial postoperative visit. It was noted that he sustained dislocations of all CMC joints requiring radial amputation to the long finger and ORIF of the 2<sup>nd</sup> metacarpal. His pins were intact. There were no opened wounds or infection. There was minimal soft tissue swelling, which was appropriate for this type of trauma. His neurosensory was intact. Cap refill was normal to the digits. There was epidermolysis along the skin edge dorsally, which would result in full thickness, skin loss, and opened wound. He was sent to rehabilitation for a fabricated splint.

10/05/11: The claimant was reevaluated who noted that his sutures were intact. There were no signs of infections or opened wounds. The small area of epidermolysis was superficial to the dorsum and "should heal uneventfully with appropriate wound care." Physical therapy and occupational therapy was ordered for wound care for the next four weeks.

11/07/11: Left Hand Series Report interpreted Services. IMPRESSION: Interval amputation of the third digit at the level of the third metacarpal. Satisfactory alignment of the second metacarpal fracture and CMC articulations. Fracture lines remain evident at the distal second metacarpal. Marked disuse osteopenia.

11/07/11: The claimant was reevaluated who noted that x-rays from that date revealed continued healing to the 2<sup>nd</sup> metacarpal head fracture. The pins remained. The transmetacarpal k-wires were removed. The metacarpal 4<sup>th</sup> and 5<sup>th</sup> k-wires were removed due with what appeared to be a healed CMC dislocation thus only two k-wires remained to the 2<sup>nd</sup> metacarpal head, which showed some absorption and however some healing as well. His dorsum and volar soft tissue were healed with minimal edema. He had a very extremely stiff entire hand except for the thumb, which was understandable due to his injury. It was noted that he may require future surgeries.

12/05/11: Left Hand AP, Lateral, Oblique Report interpreted. IMPRESSION: Satisfactory and unchanged alignment of the carpometacarpal joints and distal second metacarpal fracture status post removal of the K wires across the fourth and fifth MCP joints and the K wires spanning the second-fifth distal metacarpals. Marked disuse osteopenia.

12/05/11: The claimant was reevaluated by who noted that x-rays that day revealed healed second metacarpal fracture. The pins were removed x 3 without difficulty. He was wrapped. He was very stiff in all digits except for the thumb, which was not injured and will require flexor extensor tenolysis and capsulotomies at a later date. It was noted that they will continue with aggressive rehabilitation.

01/16/12: The claimant was reevaluated who noted that he had been very

compliant with rehabilitation and was improving. His thumb was normal. Index finger had some scissoring due to malunion of the second metacarpal, which could be corrected with a corrective osteotomy at some point. He discussed the flexor tenolysis and capsulotomies of multiple tendons and joints due to contracture, flexor contracture with inability to fully extend and loss of active range of motion. His measurements were “e-clinical works under the physical therapy notes and he does seem to be improving.”

02/27/12: The claimant was reevaluated who noted that he was approximately five months status post injury to the left hand. It was noted that he had been very compliant with rehabilitation and that his hand was improving. He had intrinsic tightness and flexor tendon adhesions, which most likely would require flexor tendon tenolysis of the second, third, and fifth digits as well as release of his lumbrical intrinsics. One K wire from the third metacarpal was removed under sterile conditions and a Band-Aid applied. He will continue with static splinting at night and static aggressive during the day as well as instructed rehabilitation.

04/09/12: The claimant was reevaluated who noted that he had done exceedingly well. He had been compliant with rehabilitation three times per week. He had healed but still had severely limited function of his left hand. He did have intrinsic tightness with flexor tendon adhesions, which limited active and passive range of motion exercises into the palm. His MCP joints were approximately 20 degrees to 30 degrees flexion and extension. His PIP joints were approximately -15 to -20 and 30 to 40 degrees. He was noted to be making progress in rehabilitation. The soft tissue of his dorsum and volar of his hand were pliable. It was noted that if he required surgery, he would need extrinsic extensor and flexor tendolysis, capsulotomies, and possible release of intrinsics.

05/08/12: Physician's Order. Continue Rehab for left shoulder and left hand 2-3 x week for 6 weeks. DX: Crush injury left hand.

05/11/12: The claimant was reevaluated, OTR/CHT who noted that the claimant stated he was, within the last month, opening doors with his left hand more with surprising success. He had experienced some phantom pain from time to time and has returned to the clinic with splint as needed for modification. He again completed DASH self-assessment with a calculated functional score today of 8/100 compared to 13/100 at his last re-evaluation on 03/19/12.

ASSESSMENT/PLAN: The patient exhibits increased MP extension on this date, most notably active movement of the digits has increased since his last progress note. He has met 1 of his 2 long term goals; however, he is not yet able to form a fist within 3 cm of his distal palmar crease. Additional goals for the patient: Perform a functional grasp enough to carry objects of 10 pounds or greater with the left hand safely. Report ability to use hammers and other tools successfully. The patient will continue to be seen 2-3 times per week for 6 weeks in order to achieve these long term goals. Treatment will consist of but not be limited to splint modifications, fluidotherapy, manual therapy, therapeutic activity, and therapeutic exercise.

05/17/12: UR performed. CONCLUSION: A significant injury was sustained to  
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the affected upper extremity on the date of injury. An extensive amount of supervised therapy services have been provided since the date of injury. After review of the case with a designated representative, would recommend 3 sessions of supervised therapy services to ensure that the claimant is fully educated on a non-supervised rehabilitation regimen. Based upon the medical documentation presently available for review, it would appear realistic to expect that there could be a transfer to a non-supervised rehabilitation regimen for the described medical situation.

05/21/12: The claimant was reevaluated who noted that he was approximately eight months status post injury but still had an extremely stiff hand. The thumb was normal. The index, ring, and small fingers had slight extensor lags with flexion contractures, limits of passive as well as active flexion at the PIP joints, which indicated extensor tendon adhesions dorsally, flexor tendon adhesion volarly, and possible Checkrein ligaments and intrinsic tightness. He was improving with rehabilitation. His MCP joints were 0 and approximately 70 degrees, PIP joint was -10 to 15 and 40 degrees. It was noted that he will eventually need extensor flexor tenolysis, capsulotomies, Checkrein ligament release, and possible intrinsic release but that would prefer additional therapy because he was improving and had been very compliant with the rehabilitation. It was noted that an attempt to obtain insurance approval for additional therapy for two months would be made.

07/20/12: The claimant was reevaluated, OTR/CHT who noted that he indicated his primary concern was that the index finger was drifting to the ring finger and interfering with making a fist, scar tissue apparent on the volar MP area also blocked his ability to straighten his ringer more. It was noted that he believed he was able to palpate pin from surgery but denied any pain associated with it. He stated that he felt that the movement was looser and he had been wearing the modified composite flexion splint, which gave greater passive movement. ASSESSMENT/PLAN: Objective measurements indicate no change in active movement of digits or wrist with modest improvement in grip strength on this date. The patient is anxious to discuss if further surgery is in plan of care in order to increase his available movement. He has two treatment sessions remaining on his current script. After which time, he will be discharged from our services unless further authorization is received. He has not yet accomplished his strengthening goal, and therefore, it stands that he increased strength by an average of 10 pounds. If he is discharged from our services to his home exercise program, he will also receive a month without charge to utilize our xxxxx.

07/23/12: The claimant was reevaluated who noted that he had no extensor lag. His thumb was normal. Index, ring, and small fingers had extensor tendon adhesions, flexor tendon adhesions. He was 0 and approximately 50 degrees of the MCP joint, 0 and approximately 30 degrees at the PIP joints of all involved digits. DIP joints were normal. He may as well have had extensor intrinsic tightness. It was noted that he will require extensive extensor, flexor tenolysis, capsulotomies once he had plateaued. It was noted that he was currently still undergoing rehabilitation two times per week and was improving. noted that he

would like for the claimant to continue rehabilitation and return to the clinic in three months. He noted that of greater concern was the scissoring that had occurred with his index finger. He noted that he will need a corrective osteotomy with immobilization, which would “hurt us with rehabilitation thus I prefer to wait on the corrective osteotomy until he has greatly improved with ring and small finger.”

07/26/12: UR performed by CONCLUSION: I spoke with medical assistant, on 07/26/12 at 12:39 PM CT. She stated that the doctor was in surgery all day so he instructed her to fax the most recent clinical note to my attention. I provided my fax number. I received a fax of a 07/23/12 office note. It is documented that the claimant will need tenolysis and capsulotomies once he has plateaued with rehabilitation. Recommend adverse determination. The claimant has attended 44 sessions of postoperative therapy with no significant change in wrist or digit motion since 06/26/12. The claimant appears to have reached a plateau in progress. Additional therapy would not be justified.

08/13/12: UR performed. History: The patient most recently presented on 07/20/12 complaining that the index finger is drifting to the ring finger and interfering with making a fist. Objective findings include essentially unchanged ranges of motion. Discussion identifies that the patient has two treatment sessions remaining and will transition to a home exercise program. Conservative care has included occupational therapy. CONCLUSION: ODG states that patients should be formally assessed after a “six-visit clinical trial” to see if the patient is moving in a positive direction, no direction, or a negative direction prior to continuing with physical therapy. A request for continuation of physical therapy would make it reasonable to require documentation of objective improvement with previous treatment and functional deficits on exam that are likely to respond to OT. However, the medical reports failed to identify objective functional improvement with previous occupational therapy. In addition, the number of visits completed to date was not readily identified. Furthermore, it is unclear why an independent home exercise program would be insufficient to address the patient’s remaining functional complaints. Lastly, there is no recent and comprehensive medical report from the requesting provider identifying a clear rationale for continued OT. Recommend non-certification. Attempts at peer to peer were unsuccessful.

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

The previous adverse decisions are upheld. The claimant has attended 46 sessions of postoperative therapy with no significant change in wrist or digit motion since 07/20/12. The claimant reached a plateau in progress according to OTR notes.

UR performed on 08/13/12 states that the claimant most recently presented on 07/20/12 complaining that the index finger is drifting to the ring finger and interfering with making a fist. Furthermore, conservative care includes occupational therapy documentation where OTR xxxxx clearly indicates in the

notes of 07/20/12 as follows, "Objective measurements indicate no change in active movement of digits or wrist with modest improvement in grip strength on this date. The patient is anxious to discuss if further surgery is in plan of care in order to increase his available movement. He has two treatment sessions remaining on his current script. After which time, he will be discharged from our services unless further authorization is received. He has not yet accomplished his strengthening goal, and therefore, it stands that he increased strength by an average of 10 pounds. If he is discharged from our services to his home exercise program, he will also receive a month without charge to utilize our xxxx xxxxx." It appears from these notes that claimant has plateaued and that full benefit from conservative care has been reached. He has been transitioned to unsupervised home exercise as endorsed by the ODG when maximum benefit from treatment is reached.

ODG states that patients should be formally assessed at "six-visit clinical trial intervals" to see if they are moving in a positive direction, no direction, or a negative direction prior to continuation of physical therapy. The medical reports clearly document no further gains in objective functional improvement with continuation of occupational therapy. The number of therapy treatments to date has been documented and claimant has been treated sufficiently with the recommended treatments for post amputation case and shows no further benefit with conservative treatment. Therefore, the request for Occupational Therapy 2 x 4 weeks – Left Hand 97110, 97530, 97022, 97010 is not medically necessary and is non-certified.

ODG:

Physical/ Occupational therapy	<p><i>ODG Physical/Occupational Therapy Guidelines –</i></p> <p>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 <a href="#">ODG Preface</a>.</p> <p><b>Fracture of carpal bone (wrist) (ICD9 814):</b> Medical treatment: 8 visits over 10 weeks Post-surgical treatment: 16 visits over 10 weeks</p> <p><b>Fracture of metacarpal bone (hand) (ICD9 815):</b> Medical treatment: 9 visits over 3 weeks Post-surgical treatment: 16 visits over 10 weeks</p> <p><b>Fracture of one or more phalanges of hand (fingers) (ICD9 816):</b> Minor, 8 visits over 5 weeks Post-surgical treatment: Complicated, 16 visits over 10 weeks</p> <p><b>Fracture of radius/ulna (forearm) (ICD9 813):</b> Medical treatment: 16 visits over 8 weeks Post-surgical treatment: 16 visits over 8 weeks</p> <p><b>Dislocation of wrist (ICD9 833):</b> Medical treatment: 9 visits over 8 weeks Post-surgical treatment (TFCC reconstruction): 16 visits over 10 weeks</p> <p><b>Dislocation of finger (ICD9 834):</b> 9 visits over 8 weeks Post-surgical treatment: 16 visits over 10 weeks</p> <p><b>Trigger finger (ICD9 727.03):</b> Post-surgical treatment: 9 visits over 8 weeks</p> <p><b>Radial styloid tenosynovitis (de Quervain's) (ICD9 727.04):</b> Medical treatment: 12 visits over 8 weeks Post-surgical treatment: 14 visits over 12 weeks</p> <p><b>Synovitis and tenosynovitis (ICD9 727.0):</b> Medical treatment: 9 visits over 8 weeks Post-surgical treatment: 14 visits over 12 weeks</p> <p><b>Mallet finger (ICD9 736.1)</b> 16 visits over 8 weeks</p> <p><b>Contracture of palmar fascia (Dupuytren's) (ICD9 728.6):</b> Post-surgical treatment: 12 visits over 8 weeks</p> <p><b>Ganglion and cyst of synovium, tendon, and bursa (ICD9 727.4):</b> Post-surgical treatment: 18 visits over 6 weeks</p> <p><b>Ulnar nerve entrapment/Cubital tunnel syndrome (ICD9 354.2):</b> Medical treatment: 14 visits over 6 weeks Post-surgical treatment: 20 visits over 10 weeks</p> <p><b>Sprains and strains of wrist and hand (ICD9 842):</b> 9 visits over 8 weeks</p> <p><b>Sprains and strains of elbow and forearm (ICD9 841):</b> Medical treatment: 9 visits over 8 weeks Post-surgical treatment/ligament repair: 24 visits over 16 weeks</p> <p><b>Open wound of finger or hand (ICD9 883):</b> 9 visits over 8 weeks. See also <a href="#">Early mobilization</a> (for tendon injuries). Post-surgical treatment/tendon repair: 24 visits over 16 weeks</p> <p><b>Pain in joint (ICD9 719.4):</b> 9 visits over 8 weeks</p> <p><b>Arthropathy, unspecified (ICD9 716.9):</b> Post-surgical treatment, arthroplasty/fusion, wrist/finger: 24 visits over 8 weeks</p>
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	<p>Amputation of thumb; finger (ICD9 885; 886):</p> <p><b>Medical treatment: 18 visits over 6 weeks</b></p> <p><b>Post-replantation surgery: 36 visits over 12 weeks</b></p> <p><b>Amputation of hand (ICD9 887):</b>  Post-replantation surgery: 48 visits over 26 weeks</p> <p><b>Work conditioning</b> (See also <a href="#">Procedure Summary</a> entry):  12 visits over 8 weeks</p> <p><b>Carpal tunnel syndrome (ICD9 354.0):</b>  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</p> <p><b>Crushing injury of hand/finger (ICD9 927.2 &amp; 927.3):</b>  9 visits over 8 weeks</p> <p><b>Contusion of upper limb (ICD9 923)</b>  6 visits over 3 weeks</p> <p><b>Crushing injury of upper limb (ICD9 927)</b>  9 visits over 8 weeks</p>
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**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 JUDGMENT, 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)