

MATUTECH, INC.

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Notice of Independent Review Decision

Date: September 5, 2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Stat-A-Dyne brace

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

Certified by the American Board of Orthopaedic Surgery
Recertified by the American Board of Orthopaedic Surgery, 2011
Orthopaedic Sports Medicine Subspecialty CAQ, ABOS, 2011

REVIEW OUTCOME:

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

TDI

- Office visits (06/11/12 - 07/13/12)
- Therapy (07/25/12 - 08/08/12)
- Utilization review (08/16/12)

Medical

- Office visits (06/11/12 - 07/13/12)
- Therapy (07/25/12 - 08/08/12)

Claims

- Office visits (01/06/12 – 07/30/12)
- Diagnostics (01/06/12 - 04/07/12)
- Therapy (02/24/12 – 07/27/12)

- Utilization review (08/16/12)

ODG has been utilized for the denial.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was on a ladder cutting pipe. The pipe end fell striking the ladder. The patient lost his balance and fell approximately eight feet. He fell on the left side and alleges injuries to his lung, left ribs and left wrist.

Following the injury, the patient was transported to the Medical Center emergency room (ER) via ambulance.

At hospital he underwent x-rays of the chest that revealed multiple left lateral rib fractures and a pulmonary contusion or atelectasis. A computerized tomography (CT) scan of the brain showed no evidence of trauma. CT scan of the cervical spine showed mild degenerative changes without evidence of trauma. CT scan of the chest showed multiple displaced and non-displaced left-sided rib fractures involving the left fourth through tenth rib with air in the adjacent left thoracic musculature fascia, small anterior pneumothorax, and small left-sided hemothorax. X-rays of the left wrist showed comminuted intra-articular fracture of the distal radius with 2 mm ulnar displacement of the distal fracture fragment and possible tiny avulsion fracture of the distal scaphoid. X-rays of the left elbow revealed olecranon enthesophyte with likely chronic fragmentation. X-rays of the tibia and fibula were unremarkable.

The patient was admitted to the intensive care unit (ICU) and a chest tube was placed on the left side. The patient had decreased breath sounds on the left, left wrist edema and ecchymosis of the dorsum, left elbow tenderness and left anterior tibia abrasion with overlying ecchymosis.

On January 9, 2012, x-rays of the chest showed interval removal of the left-sided chest tube with small residual left hydropneumothorax, unchanged multiple displaced left lateral rib fractures and minimally increased airspace opacity in the left posterior lung base, possibly consistent with atelectasis and/or small area of pulmonary contusion.

The patient was discharged with prescription for Percocet, ibuprofen and Colace.

From January 15, 2012 through February 5, 2012, the patient was admitted at for abdominal pain and urinary retention. The patient underwent splenectomy, distal pancreatectomy, and left chest tube placement. He was observed in the ICU for three days, pain controlled with Dilaudid and the chest tube was placed to the water seal. He was then transferred to the floor on January 17. Interventional radiology was consulted and a percutaneous transthoracic drain was placed into a left upper quadrant fluid collection. The patient was seen by an orthopaedic surgeon for his left distal radius fracture and his forearm was casted. A CT scan

of abdomen was obtained on February 2 that demonstrated a small fluid collection adjacent to the drain placed by interventional radiologist. They were reconsulted and adjusted the drain on February 3, which showed minimal output. The patient continued to recover well and at the time of discharge he was ambulating, voiding spontaneously, tolerating a regular diet and his pain was well controlled on oral pain medications. He was prescribed Colace, milk of magnesia, Lortab and MiraLax.

On February 13, 2012, X-rays of the left forearm showed a comminuted fracture with some impaction and extension into the radiocarpal joint.

X-rays of the left wrist showed distal radius metaphysis comminuted fracture with some impaction and slight cortical discontinuity and some extension into the radiocarpal joint. There was decreased radiocarpal angle and positive ulnar variance.

The patient was then seen at Alamo Healthcare System. It was noted that the patient's hand swelling had decreased and the evaluator recommended follow-up with a general surgeon and an orthopedic surgeon.

CT scan of the abdomen was obtained which was unremarkable for any new intra-abdominal pathology. The patient was maintained on Percocet for pain control.

Dr. noted that the patient was taken out of his prior cast and placed in a Monster cast by another orthopedic surgeon. Dr. removed the cast. X-rays showed healing of his distal radius fracture with some shortening of the radius along with healing of the ulnar fragment. Dr. recommended removable splint and starting range of motion (ROM) with occupational therapy (OT).

Dr. provided a left wrist cock up brace.

From February through April, the patient attended multiple sessions of therapy consisting of hot/cold pack, electrical stimulation, therapeutic exercises, neuromuscular re-education and myofascial release.

From February through April, the claimant presented again for abdominal pain, abdominal abscess, and closed fracture of the distal end of the left radius. The patient underwent left upper quadrant drain exchange by interventional radiologist and was continued with percutaneous drain for control of the pancreatic fistula. In March, the drain tube was removed. The patient had improvement on his left side where he had some mild rib pain associated with his rib fracture from his injury.

The patient reported pain, stiffness and decreased ROM of his left wrist despite of use of wrist brace and OT. Dr. recommended wearing a removable brace and continuing OT. Dr. noted that the patient's abdominal abscess had resolved.

In April, the patient was admitted due to increased abdominal pain. Dr. assessed re-accumulation of fluid within a rim enhancing focal fluid collection in the region of the post surgical bed from the prior distal pancreatectomy and splenectomy with concern for abscess and interval resolution of the left pleural effusion and free pelvic fluid. The patient underwent an uncomplicated drainage of fluid by an interventional radiologist with appropriate effects. He was discharged on April 7, 2012, with adequate pain control. He was prescribed Norco and Tylenol.

On follow-up, Dr. noted the patient's drain output had decreased.

On April 30, 2012, the patient was prescribed JAS wrist splint.

From May through July, the patient was seen by an unknown physician at Healthcare systems for left arm soreness, painful ROM and occasional left-sided soreness along the ribs. The patient was maintained on Motrin/ibuprofen, topical cream, rib belt, left wrist splint and was recommended use of Dynasplint.

In July, the patient attended nine sessions of work conditioning program (WCP) at Healthcare systems.

In a functional capacity evaluation (FCE), the patient demonstrated the ability to perform at light physical demand level (PDL).

On July 30, 2012, the patient was given letter of medical necessity for WHFO/Stat-A-Dyne ROM device.

In a subsequent FCE dated August 8, 2012, the patient demonstrated the ability to perform at light-to-medium PDL. The evaluator recommended additional ten sessions of WCP.

On August 10, 2012, the patient was evaluated by an unknown physician at Healthcare Systems who noted that the patient had improved since WCP. Examination showed limited strength above the shoulder. He had some strength weakness above the left wrist. The physician recommended ten more sessions of WCP and wrist hand finger orthosis to increase flexion and extension of the left and gain composite fist. The patient had deficient fist closure to perform his job. The report is illegible.

Per reconsideration review dated August 16, 2012, the request for Stat-A-Dyne brace was denied with the following rationale: *“ODG guidelines state, early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications. In this case, however, the claimant is approximately seven months removed from the date of injury and seven months removed from date of surgery. Usage of a wrist brace or wrist splint, at this point in time, is not indicated, as the fracture has been surgically fixated. Continued usage of brace or splints would only serve to promote further immobility, which is to be discouraged at this point.*

No compelling rationale for the non-standard flexible brace device has been furnished, either in writing or on teleconference, to justify a variance from the guidelines referenced below. Therefore, the request for the WHFO brace is not certified.”

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

The claimant no longer has substantial residual ankylosis of the left wrist. On 6/11/12, the claimant had substantial residual ROM deficits (30 deg extension; 20 deg flexion), which would have resulted at that time in an anticipated Impairment Rating of 12% for the wrist. However, at the most recent visit at Healthcare, the claimant’s ROM has markedly improved—now 45 degrees of extension actively. At most, this would result in a 4% Impairment Rating. The overall trajectory of recovery indicates substantial improvement. There is no indication for a static-dynamic splint at this time, despite the erroneous reporting of surgical intervention (the fracture was treated with casting, not surgery). The method of treatment is irrelevant to the decision making process.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES