

AccuReview

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Notice of Independent Review Decision

[Date notice sent to all parties]: November 13, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

CPM machine, right wrist

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

This physician is Board Certified in hand surgery 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)

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:

07-29-13: Femur 2 views X-ray
07-29-13: Hand 3 + views Bilateral X-ray
07-29-13: Wrist 3 + views Bilateral X-ray
07-30-13: Femur 2 views X-ray
07-30-13: Hip Unilateral (2 views) X-ray
07-30-13: Knee 1 or 2 views X-ray
08-09-13: Initial Evaluation
08-09-13: X-ray Wrist Right Min 3V
08-09-13: X-ray Hand Right Min 3V
08-09-13: X-ray Lumbar 2 or 3 Views
08-09-13: X-ray Forearm Right 2V
08-09-13: X-ray Femur Left 4 Views
08-16-13: Follow-up Evaluation
08-16-13: Initial Evaluation

08-28-13: Wrist Right CT
08-28-13: Hand Right CT
09-05-13: Operative Report
09-11-13: Follow-up Evaluation
09-26-13: Follow-up Evaluation
10-10-13: Follow-up Evaluation
10-11-13: Consult Request
10-16-13: UR performed
10-21-13: Request for Appeal
10-25-13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. He reported that upon rollover, the glass shattered and went all over the inside of the truck and he noticed bleeding initially from his left forearm and wrist and left eyebrow. The claimant related that he was pinned between the seat and the steering wheel of the vehicle. He had to be cut out of the vehicle. He was treated at the local emergency room on the day of the accident where multiple x-rays and CTs were taken and released.

07-29-13: Hand 3 + views Bilateral X-ray. Impression: No acute osteoarticular abnormality. Small opacities within the soft tissue may be on or within them.

07-29-13: Wrist 3 + views Bilateral X-ray. Impression: No acute osteoarticular abnormality of either wrist. Small bilateral opacities may be on or within the soft tissues.

08-09-13: Initial Evaluation. Chief complaint: The claimant requested evaluation and management of his right wrist forearm injury, discomfort to his neck and low back and resolved scrape over the left side of his face. Pain reported 6/10 in his right wrist and forearm, 6/10 in his low back and neck. Current Medications: hydrocodone 10/325 mg 2-3 times per day, docusate calcium 240 mg, Bactrim 800/160 mg, metformin, enalapril 10 mg, cyclobenzaprine 5 mg. The claimant has not returned to work since injury most due to open wounds that cannot be exposed to his current work environments. PE: Orthopedic Examination: Noted moderate degrees of swelling to the right wrist with a 10-12 small 0.5 cm lacerations due to concern of the extensive degree of swelling in the dorsum of the wrist. Discussion: Most concerned with the limited evaluation and management in the dorsum of his right wrist and request immediate radiographs. Certainly I am concerned of the described ongoing increased swelling over the last 11 days. Claimant was seen in the ER on xx/xx/xx and released 7/30/13, then further evaluated on 8/2/13 and was told he may have a fracture. On 8/8/13 he went for a follow-up and was told that radiology reports were not back yet. X-rays of bilateral wrist and medical records from both facilities, referral for evaluation and treatment of this right upper extremity what appears to be ongoing and worsening swelling since DOI, follow-up in one week. Assessment: 1. History of MVA; 2. Extensive edema in the dorsum of the right wrist; 3. Multiple lacerations of the extensor surface of the right wrist; 4. Abrasion over the left

forehead; 5. Lumbar sprain and strain; 6. Cervical sprain and strain, resolving; 7. Left rib contusion. Treatment Plan: 1. Referral a hand specialist due to the worsening on the based claimant's history, dorsum of his right wrist and hand. 2. X-rays of his right wrist and hand ASAP. 3. Request medical records and make recommendations once reviewed.

08-09-13: X-ray Wrist Right Min 3V. Impression: 1. Normal three views of the right wrist.

08-09-13: X-ray Hand Right Min 3V. Impression: 1. Osteoarthritis changes. 2. No plain film evidence of acute right hand fracture.

08-09-13: X-ray Forearm Right 2V. Impression: 1. No plain film evidence of right radius or ulnar fracture.

08-16-13: Follow-up Evaluation. Chief Complaint: Scheduled follow-up. As far as the x-ray to the forearm, hand and radius, the claimant has no identifiable fracture or dislocation. There is present multiple radiopaque foreign bodies which clearly would indicate the rationales as why the claimant has had worsening and increased swelling in the hand. He likely has foreign bodies present. Because, there were also issues of calcification present in some soft tissue in the distal pole of the scaphoid. Consulted and he agreed that there were more likely foreign bodies, however, reviewed with me the concerns for ruling out any fracture process that would be pertinent, will order CT of the wrist and hand. Referred to hand specialist. Assessment: 1. Sprain and strain of right wrist; 2. New indications of probable foreign bodies, embedded in the dorsum of the claimant's right wrist; 3. Resolving left rib contusion; 4. Lumbar sprain and strain complex; 5. Resolving cervical acceleration-deceleration syndrome. Treatment Plan: orthopedic hand specialty evaluation, follow-up in 2 weeks and once this evaluation has been accomplished.

08-16-13: Initial Evaluation. Chief complaint: right hand pain, right wrist pain, left rib cage pain, low back pain. Current pain 8/10 in the right hand area with difficulty forming a complete fist and the pain is mostly in the dorsal aspect of right hand and he finds it hard to bend the MP joints of the right second, third and the fourth digit. He also complains of mild pain in the right wrist area but it is not as severe as one in the right hand. PE: The claimant is currently wearing a right upper extremity sling with a right forearm support and the right hand is in a dressing. Musculoskeletal Exam: Right Hand: The dorsal aspect, there are multiple areas of the skin breakdown and ecchymosis with mild swelling and tenderness in the dorsal aspect of the right hand, especially around the MP joints of the second, third and fourth digits. Any movements in the MP joints make his pain worse. He has full range of motion in the left thumb and in the distal interphalangeal joints of the second, third, fourth and the fifth digit as well as the PIP joint of all the four digits. There is pain in the dorsal aspect of the MP joint especially of the middle finger and to some extent in the left and the fourth MP joint with flexion increasing his pain levels. Right Wrist: The dorsal aspect, there is again palpatory pain with restriction in the ROM. Both flexion in the right wrist

and the extension increasing his pain levels. Negative Tinel's and Phalen's signs area. Impression: 1. Right hand pain with a radiopaque abnormalities; 2. Right wrist sprain and strain; 3. Left rib cage pain; 4. Lumbar sprain and strain; 5. Multiple injuries in a rollover type accident. Plan of Treatment: All x-rays show some abnormality in the dorsal aspect of the right hand in the soft tissue, and therefore I recommend evaluation by a hand surgeon for possible surgical removal. Advised simple exercises like squeezing a ball as tolerated using right hand. Prescription given for naproxen 500 mg PO BID. Return in 2 weeks or earlier if there are any problems.

08-28-13: Wrist Right CT. Impression: 1. Multiple radiopaque foreign bodies over the dorsum of the wrist with granuloma formation.

08-28-13: Hand Right CT. Impression: 1. Multiple radiopaque foreign bodies and granuloma formation over the dorsum of the hand.

09-05-13: Operative Report. Preoperative Diagnoses: 1. Right dorsal wrist foreign body. 2. Right dorsal wrist tenosynovitis. Postoperative Diagnoses: 1. Right dorsal wrist foreign body. 2. Right dorsal wrist tenosynovitis.

09-11-13: Follow-up Evaluation. Claimant is seen today to initiate therapies within a week following a recent surgical repair. Objective Findings: Claimant has a non-adhesive bandage over his incision site, stating that it goes from the distal portion of his forearm, about 2 inches from the wrist down into the back of his right hand. He enters today with no immobilizer on his right wrist and his AROM is moderately limited with extension of wrist to just at 25 degrees. He can flex the wrist to 28 degrees. He can deviate to 14 degrees and radial deviate to 16 degrees. The claimant has been given a HEP to be moving his fingers in both flexion and full extension. Claimant noted to have excellent ROM at the DIP and the PIP at his first, second, and third digits to normal full range. At the MP, he is somewhat limited with flexion in the first and second digits limited to just about 38 degrees at the first and 33 degrees on the second MP. Discussion: The claimant was previously defined as having foreign objects in the dorsum of his hand. Removal of those during his procedure on 9/5/13. It does not appear that any other orthopedic procedure was completed since there is no immobilization and hand is not guarded. Request 12 sessions three time a week for 4 weeks, postoperative therapies as soon as approved by surgeon, and having what appears to be a debridement from foreign bodies and dorsum of his wrist during a recent rollover MVA. We will request this protocol and initiate treatment. Return after 6 sessions as recommended within ODG to ensure his ROM and grip strength is improving and that is a slow progress of this therapy to date. He has no active base therapy. He does state that the surgical repair and removal of foreign bodies seems to substantially diminish his swelling as was noted following injury. Assessment: 1. Sprain and strain of the left wrist; 2. Foreign body puncture in the dorsum of the right wrist and forearm; 3. Myalgia in the dorsum of the right wrist and forearm. Treatment Plan: Claimant is recommended for active based therapies 3x2 as well as some light myofascial and active releases in the dorsum of his forearm at the distal one third. CPT codes requested will include

two to three units 97110 as the patient can tolerate; one unit of 97140 to include some light myofascial and active releases. This will help expedite ROM, improve mobility, and therefore additional grip strength improvement. Will ascertain surgical note from 9/5/13 prior to initiating active based rehabilitative processes. Requested start date 9/18/13 and end date 10/25/13.

09-26-13: Follow-up Evaluation. Chief Complaint: right hand pain. Claimant still complained of continued pain in the dorsal aspect of his right hand with pain becoming worse when he tries to form a complete fist. He is currently out of Tramadol and naproxen and feels that ibuprofen was much more effective in controlling his pain and uses hydrocodone at night when needed. He has been released to work with restriction, but his employer has not provided the job at this time. Postoperative diagnosis was a removal of a right dorsal wrist foreign body and tenosynovectomy of the fourth dorsal compartment, index and middle finger extensor tendons. According to the detailed report, a 4 mm piece of glass was removed from the subcutaneous tissue and a fraying of the index and middle finger tendons were noted at this time. PE: Surgical incision healing well with no signs of infection noted. He is able to form a complete fist, but he does experience some pain with this activity. Wrist ROM is limited and capillary refill is intact. Deep tendon reflexes are active and symmetrical, negative for Tinel's and Phalen's sign. Sensation is intact both in the digital nerve, ulnar nerve and the median nerve. Impression: 1. Removal of a foreign body from the right hand; 2. Tenosynovectomy of the fourth dorsal compartment, index and middle finger extensor tendons; 3. Left rib cage fracture; 4. Low back pain. Plan of Treatment: Claimant is starting physical therapy, given prescription for Motrin 800 mg PO TID PRN and Norco 5/325 mg PO QHS PRN.

10-10-13: Follow-up Evaluation. The claimant has completed six trial sessions of therapy after going through surgical repair and exploration to remove foreign bodies. He also had a right wrist tenosynovitis affecting his index and middle finger on the extensor tendons surgically released on 9/5/13 and the plan initially requested postoperative rehab. It was unclear exactly what procedures were performed. Objective Findings: Claimant stated his mobility is improving, yet still has a lot of difficulty gripping and squeezing objects due to discomfort in the back of his wrist. Current pain levels range 4/10 at rest and with the use of medications intermittently up to as high as 7/10 with grasping, squeezing or flexing or extending his wrist. Examination produced mild increase or improvement in his ROM, with ability to extend wrist almost 42 degrees, forward flex the wrist at 30 degrees, ulnar deviate to 18 degrees and radial deviate to 15 degrees. ROM remains relatively unaffected in his DIP and PIP joints in the first and second digit. The MP joint was mildly stiff, with flexion to 45 degrees at the MP joint on both, extend to beyond neutral. As far as his grip strength analysis, will need evaluation with hand dynamometer. Assessment: 1. Status post foreign body removal and tenosynovectomy of the first and second compartments; 2. Myalgia in the dorsum of the right hand and wrist. Treatment Plan: 1. Claimant will proceed with six additional sessions 3x2 active based therapy. Hopeful to improve ROM at least another 20%, we will have to work on the flexion surface, which appears mostly from scar tissue formation in the dorsum of the wrist. Acquire a hand

dynamometer grip strength analysis to create a baseline. Services Requested: Requested 3x2 additional active based PT to include 3 to 4 units 97110, 1 unit of 97140, manual therapy with myofascial and active release. Requested start date 10/16/13, end date 11/1/13.

10-11-13: Consult Request. Orders: Open wound of hand except fingers with complication, ICD-9: 882.1: Open wound of hand except finger(s) alone, complicated: Physical Therapy Referral: Note to provider: CPM machine, Visits per week: 2, Number of weeks: 3. Notes: CPM machine.

10-16-13: UR performed. Reason for denial: The claimant sustained a work related injury to his right wrist on xx/xx/xx and is noted to be status post removal of foreign body at the right wrist on 9/5/13. The claimant had 6 postoperative therapy visits. The examination of 09/11/13 noted ROM is limited, extension 25 degrees, flexion 28 degrees, ulnar deviate to 14 degrees and radial deviate to 16 degrees. The physician's impression is the claimant at the MP is limited with flexion in the first and second digits limited to 38 degrees at the first and 33 degrees on the second MP, sprain and strain of the left wrist, foreign body puncture in the dorsum of the right wrist and forearm, myalgia in the dorsum of the right wrist and forearm. The physician recommends continuing physical therapy and requests a CPM unit. Based on the submitted medical records, the treatment request for CPM machine is not medically necessary. There are no peer review studies that show the CPM used 6 weeks post surgical I and D will affect outcome for a stiff wrist. It is not considered medically necessary per evidence based guidelines. Therefore, the treatment request for CPM machine is not medically necessary.

10-21-13: Request for Appeal. The Vector 1 hand CPM moves the claimant's affected hand through a pre-programmed ROM to help in the prevention of adhesion formation, to increase tissue extensibility, increase tissue nutrition to facilitate the healing process, reduce edema, and increase ROM. This unit is recommended.

10-25-13: UR performed. Reason for denial: According to ODG Hand, Continuous Passive Motion chapter, criteria have not been met for the requested CPM unit. The claimant is status post wrist tenosynovitis affecting his index and middle finger on the extensor tendons. The examination reveals wrist extension to 42, forward flexion 30, ulnar deviation (UD) 18, and radial deviation (RD) 15. The MP joint was mildly stiff, flexion 45 at the MP joints on both, and extend to beyond neutral. Motion has been noted to be still improving. The request for CPM is not medically necessary at this time. Therefore, the appeal treatment request for a CPM machine right wrist is not medically necessary.

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

Previous adverse determinations are upheld and agreed upon. After reviewing the medical records and documentation provided, the Vector 1 Hand CPM device is not clinically indicated for this type of injury nor indicated on this claimant. It

appears that with current OT and HEP, his index and long finger MCP joint function is improving (0-45) and wrist function is similar (flexion 30 and extension 42). The CPM device is usually indicated in flexor or extensor tendon injuries per ODG guidelines. Foreign body removal from the dorsum of the hand with tenosynovectomy of the fourth compartment should respond to dynamic therapy and/or static progressive hand therapy. The claimant does not meet ODG Hand Chapter criteria for the requested CPM device. Therefore, after review of submitted medical records and documentation, the request for CPM machine, right wrist is denied.

Per ODG:

Continuous passive motion (CPM)	Recommended. Controlled mobilization regimens are widely employed in rehabilitation after flexor tendon repair in the hand. One trial compared continuous passive motion (CPM) with controlled intermittent passive motion (CIPM) and found a significant difference in mean active motion favoring CPM. (Thien-Cochrane, 2004) A prospective multicenter clinical study found that greater durations of daily passive-motion rehabilitation after flexor tendon repair leads to improved tendon gliding without greater risk of injury. (Gelberman, 2001) (Bunker, 1989) (Chan, 2002)
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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 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)**