

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: May 6, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Osteotomy of the Left Middle Finger Proximal Phalanx with Internal Fixation, as outpatient

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

This physician is Board Certified in Plastic Surgery with a specialty in Hand Surgery and over 31 years of experience.

REVIEW OUTCOME:

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

Overturned (Disagree)

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]:

This claimant is a male who sustained a crush injury to his left middle finger on xx/xx/xx. He claims that a xx fell on his hand crushing his middle finger into the knuckle area. He originally presented to the ER where x-rays were taken and a splint was placed. Instructions were given to follow up with an ortho.

On xx/xx/xx, X-rays of the Left Hand, Conclusions: Comminuted fracture of the proximal phalanx, third digit, left hand.

On October 30, 2013, the claimant presented to the ED for recheck of his left middle finger. The claimant complaints of pain that is acute and aggravated by movement. He reported no other associated symptoms, no numbness distal to affected area, tingling distal to affected area, decrease sensation distal to affected area. Physical exam showed diffuse tenderness to palpation of the left middle

finger with associated swelling, minimal deformity. Limited ROM due to pain in the left middle finger. Circulation is intact. Diagnosis: Closed fracture, contusion, sprain, abrasion to left middle finger. Discharged with splint back in place and prescription for Norco.

On November 12, 2012, the claimant was for pain in his left hand and a left middle finger fracture. The claimant felt that his bones were moving around and described his pain a throbbing and getting worse. On exam there was swelling noted to all fingers and discoloration and bruising noted as well to the left hand and to the fingers. He was unable to grip on the left. Diagnosis: 1. Crush injury/fracture, left hand. Plan: 1l Referral to orthopedic surgeon and prescribed Norco.

On December 11, 2012, the claimant was evaluated. On physical examination he had a positive extensor pollicis longus. Intrinsic were intact. Fist formation was markedly limited due to decreased range of motion of his middle finger. Range of motion of the joints of his left middle finger reveals the metacarpophalangeal joint range of motion has about 5 degrees of hyperextension and 60 degrees of flexion. The proximal interphalangeal joint is about 10 degrees shy of full extension to about 45 degrees of flexion and the distal interphalangeal joint is 0 to 45 degrees of motion. He had marked difficulty pulling the middle finger down to the palm of the hand and it was at least 4 centimeters from touching the pulp in the finger to the palm of the hand. He reported decreased sensation to the tip of the middle finger when compared to the other digits, but did have normal two-point discrimination. Capillary refill was less than 3 seconds. He did complain of some tenderness to palpation over the middle finger, but much of it seemed to be with range of motion of his joints. The left middle finger was noted to have an abnormal appearance. The hyperextension at the fracture site was noticed with a visible bow to the proximal phalanx dorsally. He appeared to have about 10 degrees of ulnar deviation of the middle finger. It appeared to be coming from his proximal interphalangeal joint. X-rays were taken in the office that showed a

proximal phalanx fracture of the diaphysis with 45 degrees extension with the apex volar. Callus formation was evident, particularly dorsal to his fracture site. Impression: Left middle finger proximal phalanx fracture with malunion. Treatment Plan: Because the fracture was healing quite copiously with callus, recommended osteotomy at the fracture site with plating, but was hesitant to pursue until his ROM improved.

On March 22, 2013, the claimant had a follow-up evaluation. It was reported that there was so much time between visits because the claimant had spent some time in jail. The claimant reported he was unhappy with the appearance of the finger and with its function. He stated it tended to fold towards his ring finger and gets in the way. He also had difficulty making a full fist. The claimant reported he never had formal therapy but did exercises on his own. On examination he had no tenderness to palpation over his fracture site. He was about 10 degrees shy of full extension at the proximal interphalangeal joint to 80 degrees of flexion which was markedly improved from his previous examination. He did appear to have about 10 degrees of ulnar deviation of the distal end of the finger compared to the proximal end of the finger. With fist formation, he was about a centimeter from bringing the pulp of the middle finger down to the palm of his hand. There was an obvious extension deformity at the proximal end of his finger. There was no overt scissoring of the middle finger compared to the ring finger, but it did have a tendency to push towards the ulnar digits and did make fist formation a bit awkward. X-rays were obtained in the office and showed a significant extension at the patient's previous fracture (approximately 40 degrees) site with maturing callus, particularly posteriorly. On the AP view, he did have a slight ulnar deviation of the head of the phalanx compared to the base, approximately 10 degrees. Treatment Plan: Left middle finger proximal phalanx osteotomy with internal fixation.

On March 29, 2013, performed a UR. Rationale for Denial: Guidelines indicate open reduction internal fixation would be supported for fractures when there is radiographic evidence of a displaced fracture or comminuted fracture or open fracture with bone protrusion. Records reflect the claimant had a left middle finger proximal phalanx fracture with malunion. The X-rays were not provided for review with a radiologist's interpretation. There was no documentation of a displaced or comminuted fracture by radiologist's interpretation and no documentation the claimant had undergone any type of conservative measures other than a home exercise program. The request for an osteotomy of the left middle finger proximal phalanx with internal fixation is not pre-authorized.

On April 4, 2013, performed a UR. Rationale for Denial: The medical necessity of this request has not been determined based on supported guidelines. Therefore, the request is not recommended.

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

The previous adverse determinations are overturned. The submitted medical record is explicit in documenting a mal-union of a left middle finger proximal phalangeal fracture that was initially treated inadequately. The middle finger metacarpal is part of the rigid portion of the hand's boney architecture and as a result, deformity is poorly tolerated, as compared to the mobile ring and little finger metacarpals. Therefore, with a 40-45 degree diaphyseal extension deformity of the proximal phalanx as documented radiologically, a correctional Osteotomy of the Left Middle Finger Proximal Phalanx with Internal Fixation, as outpatient is medically necessary and should be performed without further ado.

PER ODG:

<p>Open reduction internal fixation (ORIF)</p>	<p>Recommended as an option for fractures when radiographic evidence indicates a displaced fracture or comminuted fracture, or an open fracture with bone protrusion. Open reduction internal fixation (ORIF) is a method of surgically repairing a fractured bone, in which surgery is used to reduce or set the fracture fragments and then hardware (such as a rod, plate and/or nails) is then implanted to hold the reduction in place. (Lange, 2007) Stratifying patients into low-demand and high-demand groups may improve the management of distal radius fractures. In sedentary patients with low demands, functional outcomes are good despite the presence of deformity. Patients with higher demands may benefit from fracture stabilization with locking volar plates. Volar plating with fixed-angle screws may be particularly suitable for elderly patients who may take longer to heal a fracture, be more susceptible to pin-track infection, and demonstrate earlier tendon irritation leading to rupture. (Gehrmann, 2008) Risk for radiocarpal arthritis is increased with nonsurgical treatment of displaced intra-articular fractures of the distal radius. Even minimal articular incongruency is associated with increased complications. Because nonsurgical treatment of persons with intra-articular fractures increases the risk for complications, such as radiocarpal arthritis, a referral should be strongly considered for any fracture that extends into the radiocarpal joint or the distal radioulnar joint. (Black, 2009) For average hospital LOS if criteria are met, see Hospital length of stay (LOS).</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 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)**