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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jan/06/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: LT finger proximal interphalangeal joint arthrodesis revision, LT distal radius bone graft

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery

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 medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that the request LT finger proximal interphalangeal joint arthrodesis revision, LT distal radius bone graft is not indicated as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes 02/24/09
Clinical notes 03/10/09
Clinical notes 04/10/09
Clinical notes 04/24/09
Clinical notes 09/01/09
Clinical notes 10/16/09
Clinical notes 11/07/09
Clinical notes 12/02/09
Clinical notes 12/23/09
Clinical notes 03/23/10
Clinical notes 05/05/10
Clinical notes 06/09/10
Clinical notes 07/20/10
Clinical notes 09/14/10
Clinical notes 11/16/10
Clinical notes 12/10/10
Clinical notes 03/01/11
Clinical notes 03/25/11
Clinical notes 04/07/11
Clinical notes 05/27/11
Clinical notes 06/07/11
Clinical notes 07/15/11
Clinical notes 09/15/11
Clinical notes 11/06/12

Clinical notes 12/06/12
Clinical notes 12/18/12
Clinical notes 12/20/12
Clinical notes 12/21/12
Clinical notes 01/08/13
Clinical notes 01/22/13
Clinical notes 02/22/13
Clinical notes 03/12/13
Clinical notes 04/05/13
Clinical notes 05/03/13
Clinical notes 05/31/13
Clinical notes 06/28/13
Clinical notes 07/31/13
Clinical notes 08/28/13
Clinical notes 10/16/13
Clinical notes 10/30/13
Clinical notes 12/19/13
Lab studies 03/06/13 and 03/13/13
Operative note 08/13/09
Operative note 11/30/10
CT scan left hand 03/10/11
Procedure operative report 05/17/11
Electrodiagnostic studies 10/26/11
Procedure operative report 12/21/12
Operative note 02/04/13
Operative note 03/12/13
Adverse determinations 11/12/13 and 12/02/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his left hand on xx/xx/xx. The patient stated that he initially self-treated the wound by wrapping it. However the patient developed an infection and presented the emergency room where he was referred to hand specialist. The patient underwent five tendon repair surgeries from 2005 through 2008. The patient continued with complaints of limited range of motion and dorsal pain. The patient also reported pain at PIP joints at each digit. Flexion extension exacerbated the pain at the wrist. The patient underwent prolonged course of physical therapy for approximately six months. Operative note dated 08/13/09 indicated the patient undergoing flexor tendon tenolysis at the left index, middle, and, ring and small fingers. Clinical note dated 09/14/10 mentioned the patient continuing with left hand pain. The patient returned to work with restrictions. Operative report dated 11/30/10 indicated the patient undergoing hardware removal at the left ring and small fingers. Operative re-CT scan dated 03/10/11 revealed arthrodesis of the small fingers of the left hand which were well healed and at the proximal IP joint of the ring finger. Operative report dated 05/17/11 indicated the patient undergoing revision arthrodesis of the left ring finger in the proximal at the proximal interphalangeal joint with a capsulectomy of the left small and ring fingers. Electrodiagnostic studies on 10/26/11 revealed no evidence of ulnar neuropathy. Operative report dated 12/21/12 indicated the patient underwent a wound exploration and debridement with irrigation. Operative report dated 02/04/13 indicated the patient undergoing hardware removal of the left ring finger. Operative report dated 03/12/13 indicated the patient undergoing left ring finger hardware removal and debridement irrigation. Clinical note dated 04/05/13 indicated the patient presenting with wound cellulitis at the left index and middle fingers. Clinical note dated 06/20/13 indicated the patient utilizing Cipro to address ongoing infection. The patient utilized short arm splint. Clinical note dated 07/31/13 mentioned the incisions at the left hand left upper extremity to be clean and dry with no signs of infection. Clinical note dated 10/16/13 mentioned the patient complaining of pain and swelling at the left upper extremity. Mild swelling was noted upon palpation. Range of motion was limited secondary to ongoing complaints of pain. Clinical note dated 10/30/13 indicated the patient utilizing a brace at the left hand. The patient was a current everyday smoker. Utilization review dated 11/12/13 resulted in denial for IP joint arthrodesis revision as no information was submitted regarding recent x-rays confirming non-union. Utilization review dated

12/02/13 resulted in denial for revision surgery as no x-rays were submitted confirming pathology.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: Clinical documentation submitted for review notes the patient undergoing several operative procedures at the left hand secondary to a significant puncture wound. Arthrodesis revision would be indicated provided that the patient meets specific criteria, including imaging studies confirming malunion. No updated imaging studies were submitted confirming malunion at the left digits. As such, it is the opinion of this reviewer that the request LT finger proximal interphalangeal joint arthrodesis revision, LT distal radius bone graft is not indicated as medically necessary.

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

ACOEM-AMERICA 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)