

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: July 22, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

splint 3 month rental

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

This physician is Board Certified Orthopaedic Surgeon with over 15 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:

02-24-14: MRI Right Shoulder without Contrast, MRI Right Upper Extremity/Non Joint without Contrast at Imaging

02-26-14: Office Visit

02-27-14: Operative Report at Medical Center

03-10-14: Office Visit

03-12-14: Physical Therapy Notes

03-28-14: Office Visit

04-18-14: Office Visit

05-05-14: Physical Therapy Notes

05-14-14: Physical Therapy Notes

05-16-14: Office Visit

05-16-14: Prescription

05-22-14: UR

05-28-14: Letter of Appeal

06-06-14: UR
06-11-14: Letter of Medical Necessity
06-18-14: Physical Therapy Notes
06-20-14: Office Visit
06-27-14: Letter of Appeal/Reconsideration
07-01-14: Prescription
07-02-14: Letter of Approval

Static Progressive Splinting for Restoration of Rotational Motion of the Forearm, Journal of Hand Therapy 2009: Vol 22 Issue 1: 3-9

Static Progressive Stretch Pro/Sup Product Description REV 11/5/12

Bibliography: Mechanical Stretch Therapy for Restoring Joint Range of Motion, Revised 3/28/14

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male that was injured on xx/xx/xx. The claimant injured his right arm while on the job when he tripped over something and fell. He heard a pop in his elbow when he fell, diagnosed with a right rupture of the distal bicep tendon. He had complaints of joint pain, muscle weakness, and stiffness.

02-24-14: MRI Right Shoulder without Contrast, MRI Right Upper Extremity/Non Joint without Contrast. Impression: 1. there is complete rupture of the distal biceps tendon at the elbow with tendon retraction, orthopedic surgical referral is recommended. This finding was discussed. 2. There is a small partial-thickness undersurface tear of the supraspinatus tendon insertion. 3. There is mild chronic arthrosis of the acromioclavicular joint.

02-26-14: Office Visit. Chief complaint: Right distal biceps tendon rupture. ROS: musculoskeletal: complaints of joint pain, muscle weakness, stiffness. PE: There is proximal migration of the distal biceps tendon appreciated. There is bruising and ecchymosis to the antecubital and medial elbow region. Biceps tendon is not palpable in the antecubital region. Pain and weakness with attempted supination of the forearm. Decreased flexion and extension secondary to pain. Impression: elbow sprain 841.9. Plan: awaiting approval from workman's comp for surgical stabilization of the distal biceps tendon. Continue to wear sling, activity restricted.

02-27-14: Operative Report. Preoperative Diagnosis: right distal biceps tendon rupture. Postoperative diagnosis: right distal biceps tendon rupture.

03-28-14: Office Visit. Chief complaint: right distal biceps tendon rupture. PE: Elbow exam: incisions healing well, minimal amount of swelling appreciated. Some mild pain to palpation over the antecubital region and biceps tendon. Proximally 40 degrees of supination of the forearm, currently lacking approximately 15 degrees of full extension. Current problem: elbow sprain 841.9. Other plans: HEP, PT. Claimant instructed on gradually increased ROM in his hinged elbow brace. No lifting, pushing, or pulling activities with the right upper extremity, heat and ice treatment.

04-18-14: Office Visit. Chief complaint: right distal biceps tendon rupture. Associated symptoms: weight gain, ROM restriction, swelling. PE: Elbow exam: continues to have considerable restricted ROM especially to supination. Mild tenderness palpation over the extensor muscle group. Current problem: elbow sprain 841.9. Current medications: Norco 5/325, promethazine HCL 25 mg. Plan: new medications: ibuprofen 800mg, Medrol pak 4mg. Other plans: HEP, PT, claimant will be given full ROM of his elbow brace, gradually wean from his elbow brace over the next 2 weeks, continue outpatient PT, activity restricted as discussed and Medrol Dosepak followed by ibuprofen as instructed.

05-16-14: Office Visit. Chief complaint: right distal biceps tendon rupture. Associated symptoms: weakness, ROM restriction. PE: Elbow exam: Actively the claimant nears full flexion and lacks approximately 5 degrees of full extension. He continues to have significant limitation with supination of only approximately 30 degrees, pronation proximally 70 degrees. Current problem: elbow sprain 841.9. Current medications: ibuprofen 800mg, Medrol Pak 4mg, Norco 5/325, promethazine HCL 25 mg. Plan: HEP, PT, continue outpatient PT and home rehabilitation program. Request a splint to assist with his pronation and supination.

05-16-14: Prescription. splint (supinator), 3 months. Dx; distal biceps tendon rupture 841.9.

05-22-14: UR. Reason for denial: The diagnosis of biceps tendon rupture. A medical document dated 5/16/14 indicated that there were symptoms of pain in the right upper extremity described as a 3/10. Objectively, sensation was documented to be intact in the affected upper extremity. There was no documentation of near full flexion of the right elbow. It was documented that the claimant lacked approximately 5 of full extension. The neurological examination was documented to be intact. A medical document dated 4/18/14 indicated that objectively, there was tenderness to palpation over the extensor muscle group in the affected upper extremity. It is documented on 2/27/14 surgery was performed to the right upper extremity in the form of a primary repair of a distal biceps tendon rupture. It is documented that on the date of injury, the claimant tripped and felt a pull in the right elbow. A right shoulder MRI obtained on 2/24/14 revealed a complete rupture of the distal biceps tendon at the elbow with retraction. Based upon the medical evidence presently available for review, the ODG guideline criteria Elbow Chapter would not support this specific request to be one of medical necessity. The records available for review would appear to indicate that there is range of motion in the affected elbow which is near functional capabilities. This specific request would appear to be excessive for the described medical situation, particularly given the length of rental requested.

05-28-14: Letter of Appeal. The denial letter stated that the ROM in the affected elbow is near functional capabilities but the claimant needs a device to help with his pronation and supination not elbow flexion and extension. The device is a bi-directional static progressive stretch device. It is used to increase ROM for pronation and supination. It is a monthly rental item. It is used an average of 3

times a day in 30-40 minute sessions for 1-4 months. We request that the denial be reversed.

06-06-14: UR. Reason for denial: The claimant is status post a repair of the distal biceps done in February 2014. The physician's records reflect that he has near full flexion and he is lacking 5 degrees of full extension. It is not clear as to the extent of therapy that he has completed to date and the request for the splint for 3 month rental would exceed that allowed by guidelines. Absent physician discussion to clarify the requested 3 month rental of the splint cannot be recommended as medically necessary. Peer to peer was unsuccessful.

06-11-14: Letter of Medical Necessity. The claimant presented with a significant ROM deficit and restriction of motion has been limited despite aggressive skilled therapy. Prolonged delay in restoring functional length of shortened connective tissue will lead to permanent tissue shortening, loss of joint function, and potential need for additional reconstructive surgeries. For this reason he was prescribed the Static Progressive Stretch (SPS) pronation/supination device manufactured to be utilized in a HEP, as an adjunct therapy. ROM is permanently restored in shorter overall time, the average period of use being 1-4 months with SPS vs. 3-6 months with a Dinasplint as published in the literature. This represents significant cost savings with respect to device rental needs, reduction in overall rehabilitation costs, and earlier returns to function and work.

06-18-14: Physical Therapy Notes. Claimant reported doing okay, his extension and flexion are doing well and he continues to have pain through his forearm periodically. His chief complaint is inability to supinate which limits his ability to perform household chores, lift and carry items, and perform work duties. Objective findings: PROM 0/3/150 degrees. Patient response to treatment: at this time, the claimant demonstrates within functional limits elbow extension and flexion ROM. He continued to demonstrate limitations through the wrist in his ROM, but his greatest limitation is in his supination passively and actively. This is also limiting him the most functionally. Over the last 4 weeks, he has shown insignificant improvement in his supination PROM or AROM despite attending therapy and working on this daily at home. This lack of progression over a month's time warrants more consistent and aggressive measures. The static progressive splint that the patient can use daily for hours at a time would be necessary to successfully treat this current deficit in the best course of action at this time.

07-01-14: Prescription. Dyna splint pronation/supination.

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

The previous adverse determinations are upheld and agreed upon. The claimant does not require a three-month rental of a splint. The Official Disability Guidelines (ODG) supports static progressive stretch devices for a maximum period of eight weeks. This device can be useful for established contractures when passive range of motion is restricted. The claimant underwent a distal biceps repair in February 2014. According to a June 2014 physical therapy note, the patient had

54 degrees of active supination of the right forearm. He had 67 degrees of passive forearm supination. A static progressive splint was recommended to improve his forearm supination. The functional range of motion for the forearm is between 50 degree of pronation and 50 degrees of supination. The patient's supination falls within this functional range of motion. He does not have restricted passive motion, which is a requirement of the ODG for this device. In addition, the three-month rental period is not supported by the ODG. Therefore, after reviewing the medical records and documentation provided, the request for splint 3 month rental is not medically necessary and denied.

Per ODG:

<p>Static progressive stretch (SPS) therapy</p>	<p>Recommended as indicated below. Static progressive stretch (SPS) therapy uses mechanical devices for joint stiffness and contracture to be worn across a stiff or contracted joint and provide incremented tension in order to increase range of motion. (Bonutti, 1994) (Stasinopoulos, 2005) (Doornberg, 2006) (BlueCross BlueShield, 2003)</p> <p>Criteria for the use of static progressive stretch (SPS) therapy: A mechanical device for joint stiffness or contracture may be considered appropriate for up to eight weeks when used for one of the following conditions:</p> <ol style="list-style-type: none"> 1. Joint stiffness caused by immobilization 2. Established contractures when passive ROM is restricted 3. Healing soft tissue that can benefit from constant low-intensity tension
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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)**