

## NOTICE OF INDEPENDENT REVIEW DECISION

**Date:** January 5, 2004

**RE: MDR Tracking #:** M2-04-0524-01  
**IRO Certificate #:** 5242

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery and has an ADL Level 1. The Orthopedic Surgeon physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### **Clinical History**

This review involves a now 35-year old male with an apparent work-related crush injury to the right index finger on \_\_\_, which involved a comminuted fracture presumably restricted to that index finger. After initial internal fixation of the fracture (? open vs. percutaneous), the claimant apparently underwent fairly extensive physical. /occupational hand rehabilitation therapy to improve the range of motion with limited success. Seen by a different hand surgeon essentially one year post-injury on \_\_\_, there was a request for further surgery to hopefully improve range of motion and sensation. At some point, there was apparently an EMG performed that was reportedly negative though the details are not available to me. After initial denial apparently as a result of insufficient information or documentation, the current situation is under further appeal. It should be appreciated that the only serious documentation provided stems from the requesting surgeon's notes of 04/28/03 and 06/23/03, as well as limited rebuttal letter from the surgeon dated 09/12/03. The following opinion is based solely upon the submitted documentation absent the opportunity to personally examine the claimant.

### **Requested Service(s)**

Surgical services of contracture release of the proximal interphalangeal joint, flexor tenolysis, and possible neurolysis.

### **Decision**

I agree with the insurance carrier that he request is not medically necessary.

### **Rationale/Basis for Decision**

I am in some level of sympathy relative to the claimant's plight and the surgeon's good intentions. While contracture release, tendon adhesion release, and nerve adhesion release, and nerve adhesion release as requested can be at times useful, the requested procedure in this case has little potential for success, and may turn out to be a "long run for a short slide." My main rationale for not appreciating the medical necessity of the requested surgery has to do with virtually no documentation by the requesting surgeon of the bone and joint status such as by simple x-ray.

While the details are not available to me, this comminuted fracture may have been intra-articular which may well compromise any attempt at soft tissue release. Even if not intra-articular, the minimum of documentation would include some assessment of joint contour by x-ray prior to any further surgery. Additionally, the clinical picture is not well given by the requesting surgeon in terms of active extension but appears to focus on the lack of full proximal interphalangeal joint flexion. Dependent upon the clinical picture, consideration may well have been given to not only flexor release but possibly extensor release as well. Moreover, the success of neurolysis and contracture release at this late date is guarded at best. More importantly, the surgeon does not detail whether the possible neurolysis involves the more important pinch radial side of both, and does not indicate the level of dysesthesia nor the level of fracture. While the EMG is frankly irrelevant and frankly unnecessary for this injury, the physician does need to detail the level of involvement and the extent of involvement to provide some guidance for prognosis. The claimant apparently has some protective sensation, though continuity of one of both digital nerves could be somewhat assessed by simple water soaking/skin wrinkling testing. Nonetheless, the nearly two year passage of time does not contribute to an increased success rate. While some of the timing is not directly the requesting surgeon's fault, better records or documentation of explanation of anticipated goals would have facilitated this process.

The notes indicate only 1 cm. distance of inability of the index finger to reach the palm and it is certainly debatable whether the proposed surgery would improve the situation enough to warrant the intervention, or might frankly worsen the situation. It has been my experience that most claimants in similar situations will learn to automatically substitute the long finger for many of the usual activities of daily living previously provided by the index finger, if that index finger has impaired sensation or pain with usage. Additionally, the claimant appears to complain of pain at the proximal interphalangeal joint which is usually as a result of joint pathology of post-traumatic arthritis rather than the contracture of previous soft tissue injury. The pain might be better addressed by arthrodesis (fusion) rather than subjecting this claimant to the requested surgical services. I would be happy to reconsider my position if the requesting surgeon can provide better information as well as a more reasonable argument for the surgery.

**If disputing a spinal surgery prospective decision**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (preauthorization) decisions**, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk  
P.O. Box 17787  
Austin, Texas 78744  
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.