Notice of Independent Review Decision - WC

DATE OF REVIEW: 03/23/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Surgery - Tenolysis of Extensor Tendon & Flexor of the right thumb capsulectomy

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

Board Certified in 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 or not medical necessity exists for each of the health care services in dispute:

- Surgery - Tenolysis of Extensor Tendon & Flexor of the right thumb capsulectomy - Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male with a xx/xx/xx date of injury, but the mechanism of injury is unknown. The injured employee has undergone previous tenolysis. stated that the patient had limited range of motion of the right thumb with little movement with abduction or circumduction, and difficulty in apposition. The patient was referred for second tenolysis surgery with no postoperative bracing followed by aggressive active physical therapy to improve range of motion, as well as improve functionality of the right hand.

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

Medical necessity is not established. ODG states that tenolysis of previous surgery requires a delay of 6 months post op in order to prevent tendon rupture. Furthermore, 3 months of PT must be done prior to repeat tenolysis. The initial surgery was done last 09/23/2014 and 3 months of PT has not been completed. The patient apparently was not compliant with therapy after the first surgery, and there is a lack of documentation of his range of motion and pain scores. There is insufficient information to recommend surgery, and the patient does not meet the ODG criteria. Therefore I recommend upholding the prior non-certification.

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

- ☒ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☒ **ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**