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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: X

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

REVIEW OUTCOME:

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

☒ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☐ Upheld	Agree

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X

PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who was injured on X. X was injured when X thumb was X. The diagnoses included crushing injury of right thumb and contusion of right thumb with possible tendon injury, status post crush injury.

On X, X was seen by X, APRN / X, MD for right thumb contusion. X reported swelling and decreased range of motion (ROM). Since the prior visit, X stated there was no change in X condition. X had complaints of right wrist and right thumb. X stated physical therapy was approved and went to evaluation. X then went to emergency room (ER) due to shaking in right hand. X stated X leg was shaking as well. X was prescribed X, but had not started taking yet. X was given X in ER. X was diagnosed with muscle spasm. X pain was rated as 5/10 pain but with movement. X was recommended to start physical therapy the coming week.

On X, X presented to X, MD for crush injury to the right thumb. X was seen in the X Clinic on X with complaints of pain, swelling and limited range of motion X. X pain was rated as 1/10 and increased to a 5/10 with movement of the thumb. X had completed X MRI study and presented for follow up visit. The MRI completed on X was significant for mild to

moderate swelling of the thumb consistent with a contusion. No significant tendon or ligamentous pathology was identified. X stated there had been no change in X status. At the time, X was unable to extend or flex the right thumb X. The authorization for X denied. X still reported X was unable to move the X. X also complained of thumb pain and right-hand weakness. X also reported the right-hand weakness was progressive. Examination of the right thumb was significant for X. There was moderate pain on palpation over the X. X recently went for X impairment rating (IR). The designated doctor stated that X had not reached MMI at the time and recommended therapy. X had been to initial therapy evaluation and would continue in therapy over the coming few weeks. X was recommended due to significant loss of range of motion at the X.

X had a physical therapy initial evaluation by X, PT on X for right thumb injury. X presented to the clinic, X. X mentioned since the incident X had not been able to raise X hand or bend it. X was sent to a specialist who was concerned that X flexor tendon may be lacerated and wanted X to undergo X. X was then sent to therapy to determine if it could help get X hand back to normal. X had swelling and weak grip. Pain at best, at worst and at the time of visit was rated as 5/10. Pain was described as aching, throbbing, tingling, numbness, dull, sharp, worse in morning, worse in evening and was constant. Pain was aggravated by reaching / extending and applying pressure. Pain was alleviated by rest and icing. Quick Dash score was “51.0; 90.9”. Examination showed range of motion included wrist flexion on left side to 82 degrees and right side to 60 degrees, wrist extension to left 80 degrees and right 25 degrees, wrist ulnar deviation on left and right to 35 degrees and wrist radial deviation on left to 55 degrees and right to 24 degrees. Thumb interphalangeal flexion on left was 75 degrees and on right was 63 degrees. Thumb metatarsophalangeal flexion on left was 70 degrees and on right to 55 degrees. X was recommended.

Per a Designated Doctor Examination dated X, X, DC opined that X had not reached maximum medical improvement (MMI) and the expected date of MMI was X. Rationale: X continued with functional deficit of X right wrist and hand including weakness and decreased motion. Examination of X right hand showed swelling and discoloration suggestive of complex regional pain syndrome (CRPS). The recent MRI findings showed the development of tendinopathy and tenosynovitis. Review of medical records indicated X had no formal physical therapy. X would in all medical probability benefit from a course of ODG suggested X for X injury.

X-rays of the right first finger dated X showed no gross evidence of acute fracture or dislocation. Minute nonspecific density was noted within the soft tissue at the palmar aspect of the first interphalangeal joint region. This finding suggested foreign body. An MRI of the right wrist dated X showed small amount of joint effusion. No recent fracture line could be identified. The age of onset was acute. An MRI of the right hand dated X revealed superficial edema encircling the thumb finger with picture suggestive of tendinopathy of the flexor tendon with tenosynovitis. No fracture was noted. The age of onset was acute. Treatment to date included X.

Per a utilization review adverse determination letter dated X by X, MD, the request for X was denied. Rationale: “Per ODG by MCG, Forearm, Wrist and Hand Chapter, Online Version, (Updated November 1, 2024), X. In this case, the patient has right thumb pain. The most recent follow up examination on X indicates continued subjective complaints of right thumb pain and he continues to be unable to extend or flex right thumb X. The physical examination findings note continued swelling and absence flexion and extension of X However, the patient has been treated with an unspecified amount of X. The guidelines do not support X beyond the acute to subacute phase of injury and there is no clear rationale for going outside of guideline recommendations. At this point the guidelines recommend fading of therapy and transitioning to an independent exercise program Therefore, X is not certified.”

Per a Peer Review Report dated X by X, DO, the request for X was denied. Rationale: “In regard to requested X, as stated in the guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. ODG guidelines allow for X. Guidelines indicate that for Crushing injury of hand/finger: X is appropriate. Guidelines recommend X should be tapered and transition into a self-directed home program. In this case, the clinical summary states that prior treatments include an unknown amount of X, and there is no documentation of measurable objective functional improvement through prior treatment as there was still pain, weakness, and loss of motion. Also, it is unclear why additional X been requested which exceeds guideline recommendations. Given the length of time since DOI, it is unclear why claimant cannot be directed to self HEP by now as there are no barriers to self-home

exercise program noted and no recent exacerbations to clarify why X is necessary. Therefore, Appeal X is not medically necessary."

Thoroughly reviewed provided records including provider notes and peer reviews.

Patient with continued pain and functional deficits involving right thumb for which X is indicated as a primary treatment or adjunct to other interventions. Unclear if patient can transition to home exercise program given extent of injuries. Care under X is necessary in order to ensure best return of thumb function. ODG recommendations for amount of X are guidelines and not strict rules. Thus, X is warranted. X is medically necessary and certified

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

Thoroughly reviewed provided records including provider notes and peer reviews.

Patient with continued pain and functional deficits involving right thumb for which X is indicated as a primary treatment or adjunct to other interventions. Unclear if patient can transition to home exercise program given extent of injuries. Care under X is necessary in order to ensure best return of thumb function. ODG recommendations for amount of X are guidelines and not strict rules. Thus, X requested is warranted. X is medically necessary and certified

Overturned

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

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ TMF SCREENING CRITERIA MANUAL

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ MILLIMAN CARE GUIDELINES

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ INTERQUAL CRITERIA

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE