



MedHealth Review, Inc.
422 Panther Peak Drive
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 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

The reviewer is a Medical Doctor who is board-certified in X

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of X

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a X who sustained an industrial injury on X and is seeking authorization for X.

X-rays of the right hand dated X has findings of an acute comminuted fracture of the mid fifth metacarpal with mild soft tissue swelling. X-rays of the right hand dated X has findings of screw fixation of the small finger metacarpal fracture is seen with improved alignment; no hardware complication is identified; disuse osteopenia and soft tissue swelling. X-rays of the right hand dated X has findings X. X-rays of the right hand dated X has findings of X. X-rays of the right hand dated X has findings of X. X-rays of the right hand dated X, as noted on the

exam, show X. Computed tomography of the right hand as noted on the X exam showed X. Computed tomography of the right hand dated X has X. Findings X. X-rays of the right hand dated X has X.

Previous treatments have included X. Previous surgeries X. Emergency department note dated X has the injured worker with right hand and right arm pain after an X. The exam reveals swelling and tenderness present of the right wrist and hand. X-rays were noted to X. X is discharged home with pain medication and plans made to move forward with surgery. X Note dated X has the injured worker with right small finger metacarpal (MC) shaft fracture. X works as a X and X. X is a "X". The exam of the right hand reveals tenderness to palpation of the X. Skin is intact. There is mild clinical deformity. X-rays show a X.

Operative report dated X is for an X. Orthopedic Clinic Note dated X has the injured worker X. X reports pain at the surgical site that is constant, throbbing, and worse if X hits it against anything. X mostly keeps the hand wrapped in bandage. X is reluctant to use the hand. The exam X. There is decreased range of motion in the X. The treatment plan included X.

Orthopaedic post-op clinic note dated X has the injured worker doing well with pain controlled. X noticed a couple of white sutures sticking out of the distal portion of the wound. No drainage is noted. Swelling is concerning X today. X has some pain and swelling distal aspect of the incision with concerns of possible infection. The exam reveals expected tenderness to palpation along the incision line. Minor bruising is noted. At the X. X has decreased X. The treatment plan included X. Orthopaedic post-op clinic note dated X has the injured worker doing okay. X feels like X is not progressing as X should. X has been doing X which helps a lot. Still missing last bit of X. The exam reveals incision is healed with no signs of infection. There is swelling over the MC (metacarpal) incision on the small finger. X is lacking the last 10-15 degrees of flexion at the PIP and DIP of the small finger. X-rays were reviewed which shows the X. The treatment plan included X. Orthopaedic post-op clinic note dated X has the injured worker doing better today but still having pain in X hand and contracture at X small finger PIP joint. X has been working with X. Still on light duty at work. X is unable to X. X notes the right small finger seems to want to overlap the ring finger compared to the other side. The exam reveals a healed incision with no signs of infection. Swelling over the MC incision and over small finger improved. There is tenderness to palpation over the fracture site. X has about 5 degrees of internal rotation of small finger with full composite flexion. Stiff PIP joint with flexion contracture. The x-ray from X was reviewed and shows X. Interval bridging callous noted with fracture slowly consolidating. The treatment plan included X.

Progress report dated X has the injured worker with doing better but still having pain in his hand and contracture at X small finger proximal interphalangeal (PIP) joint. X has been working with X. X is on light duty at work. X states the small finger seems to want to overlap the ring finger compared to the other side. The exam reveals the incision is healed with no signs of infection. Swelling over the metacarpal incision over the small finger improved. There is tenderness to

palpation over the fracture site. X has about 5 degrees of "IR" of small finger with full composite flexion. There is a stiff PIP joint with a flexion contracture. The treatment plan included continuation of X. X re-evaluation report dated X has the injured worker reporting a X. X has been using X on the right small finger PIPJ (proximal interphalangeal joint) but does not feel it has been helping much. This is X. X pain is rated 7/10 initial and 8/10 post. X tolerated X well. X presents with right hand decreased pinch/grip strength and decreased muscle strength and endurance. X has increased pain and scarring. X has decreased active/passive range of motion of the right small finger. X would benefit from continued X.

Progress report dated X has the injured worker with right ulnar sided hand pain. X is status X. X has pain over X. X has pain in X. X reports the flexion contracture of small finger PIPJ that has not fully resolved despite X. X denies numbness and paresthesias. The exam reveals a 30-degree flexion contracture of the PIPJ of the right small finger. There is tenderness to palpation over the fracture site. There is tenderness with grinding of the X. Range of motion is lacking 25 degrees of extension in the PIPJ of the small finger. X-rays from this date show X.

Progress report dated X has the injured worker with not much change lately. X is still concerned about the PIPJ contracture. The exam reveals the incision is healed with no signs of infection. Full range of motion of the MCPJ. PIPJ contracture of about 40 degrees semi-flexible can passively stretch down to 20 degrees of extension. The fracture appears to be healing per CT and today's x-ray with resultant PIPJ contracture. X will follow up with Dr. X regarding consideration of contracture release surgery. Progress report dated X has the injured worker with continued pain of the X head that has not improved. The exam reveals a well-healed incision. There is a 30-degree flexion contracture of the PIPJ of the small finger. Tenderness to palpation is noted over the fracture site. Tenderness with grinding is noted of the X. The range of motion is lacking 25 degrees of extension in the PIPJ of the small finger. The treatment plan included possible screw removal or scar release and tenolysis as well as option of digit widget for small finger PIPJ flexion contracture.

Progress report dated X has the injured worker seen for a 2nd opinion of the right hand. X has developed a PIPJ (proximal interphalangeal joint) contracture in the interim due to extensor mechanism scarring and pain. The exam reveals tenderness over the volar aspect of the fracture site. RSF (right small finger) PIPJ contracture, rigid and 30 degrees (volar) with extensor mechanism tethering dorsally, well healed surgical scar. The treatment plan X.

The utilization review dated X certified the requested X. The utilization review dated X certified the requested continued X. The utilization review dated X certified the requested X. The utilization review dated X non-certified the X. The principal reason for determination stated X would have been medically necessary to address the residual findings to the right hand. The requested X are not medically necessary as this will exceed guideline recommendations. The request for authorization dated X was for a X.

The utilization review dated X non-certified the requested X. The principal reason for determination was the request for the X is not medically necessary as a separately identifiable procedure from X. Adverse determination of appeal dated X has the principal reason for determination as the request for X is not medically necessary as a separately identifiable procedure from X. As the provider was not available to discuss a modified treatment plan, the request in full is not supported.

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

Regarding the request for X, As per ODG, “Recommended as an option for fractures with radiographic displacement and/or comminution, or for open fractures with bone protrusion. Criteria for Surgery: Open fracture(s); Unstable fracture(s); Displaced fracture(s); Comminuted fracture(s); Joint instability or dislocation; Fracture through pathologic bone (e.g., bone cyst, bone metastasis); Neurovascular compromise; Failed closed reduction (e.g., nonunion, malunion).

As per ODG, “Recommended as indicated below, X.” As per ODG, “Not recommended for routine removal of hardware implanted for fracture fixation, except with exposed or prominent pins, broken hardware, or persistent pain after ruling out other causes of pain such as infection and nonunion. Not recommended solely to protect against allergy, carcinogenesis, or metal detection.”

As per Pal et al, “Flexion contracture of the proximal interphalangeal (PIP) joint is a common yet complex clinical problem. Movement at this joint is responsible for 85% of the total composite motion of the digit; therefore, a contracture can significantly impair global hand function, in particular when more than one digit is involved. Chronic pain, stiffness, and functional deficits can occur, especially in severe cases or when multiple fingers are affected. Management is complicated by the complex anatomy of the PIP joint, and the causative structure is difficult to identify. The anatomical structures of the PIP joint to be evaluated and addressed if pathologic include the articular surface, capsule, collateral ligaments, volar plate, extrinsic tendons and sheaths and the skin.

Early aggressive supervised therapy does not ensure prevention, and open surgical release is technically challenging, often resulting in disappointing long-term outcomes despite thorough evaluation and careful patient selection.

Surgical options for correcting PIP joint contractures encompass arthrolysis, tenolysis, capsulotomy/capsulectomy, local flaps, and skin grafts, with arthrodesis or amputation sometimes necessary for severe cases.

Notably, Sprague⁴ reported a complete loss of the operative gain at the 1-year follow-up. Ghidella et al presented their results with a minimum follow up of 24 months in 68 contracted PIP joints treated by serial capsulectomy. The average improvement in active motion was 8°, with a revision rate of 35%. Over the past 20 years, external fixation of contracted PIP joints using ligamentotaxis distraction has gained popularity due to its simplicity, effectiveness, and minimal invasiveness, reducing the risk of complications associated with open surgery and yielding good functional outcomes in various studies.”

In this case, this X sustained an industrial injury on X and is seeking authorization for X. Overall, X presented on X for a 2nd opinion of the right hand. X has developed a PIPJ (proximal interphalangeal joint) contracture in the interim due to extensor mechanism scarring and pain. The exam reveals tenderness over the volar aspect of the fracture site. RSF (right small finger) PIPJ contracture, rigid and 30 degrees (volar) with extensor mechanism tethering dorsally, well healed surgical scar.

However, detailed documentation is not evident regarding formal diagnostic testing studies corroborating a non-union of the right 5th metacarpal fracture. The documented x-rays were noted to show callous formation on both the X and the X x-rays. The X formal CT report noted healing mid diaphyseal small finger metacarpal fracture is demonstrated; focal nonbridging cortices are seen along the volar margin of the fracture head with partial periosteal bridging along the radial, dorsal, and ulnar margins of the fracture; however, persistent cortical lucency is noted at these sites; no peri-hardware lucency is seen; there are no acute fractures; no subluxations are identified.

This is further corroborated by the progress report dated X in which it notes “the fracture appears to be healing per CT and today’s x-ray, with resultant PIPJ contracture”. Moreover, the requested X has insufficient evidence in current literature to determine that it is standard medical treatment. There is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception.

Therefore, the requested X is not medically necessary.

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
- AHRQ- 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
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)