Pure Resolutions LLC

Notice of Independent Review Decision

Pure Resolutions LLC
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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

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PATIENT CLINICAL HISTORY [SUMMARY]:

X is a X who was injured at work on x. X had a X injury resulting in right index finger phalanx 1 (P1) spiral fracture with 50% involvement of proximal interphalangeal joint (PIPJ) with radial volar displacement and right middle finger open distal spiral versus oblique fracture of P1 with volar dislocation of remainder of digit. The diagnosis was right finger stiffness.

On X, X, MD, saw X for follow-up of open displaced fracture of proximal phalanx of right middle finger with routine healing. On X, X had undergone open reduction internal fixation (ORIF) of intra-articular right index finger proximal phalanx fracture; ORIF of intra-articular right middle finger middle phalanx fracture; repair of right middle finger central slip; repair of right middle finger radial collateral ligament; simple repair of palm laceration - 2 cm. At the time, X presented for planned follow-up after the above procedure. X reported X had continued to work with therapy twice a week and felt like X had made more progress with middle finger range of motion; however, X noted no significant improvement in X index finger over the last X or so. X was otherwise well. Right upper extremity examination revealed 5/5 strength with thumb extension, thumb interphalangeal (IP) joint flexion, normal alignment, and no malrotation at rest. The index finger proximal interphalangeal (PIP) was fixed in flexion from 30-40 degrees, equal active and passive range of motion, distal interphalangeal (DIP) held in moderate flexion which X reported was chronic. Middle finger PIP was with 20 degrees of extensor lag, active flexion to 90 degrees, passive to 95 degrees. The assessment was open displaced fracture of proximal phalanx of right middle finger with routine healing and right finger stiffness. Dr. X noted that X had made some progress with ROM with therapy and could get X middle fingertip to the palm after therapy sessions; however, X index finger remained significantly stiff with limited range of motion at the PIP joint with a range of motion arc limited from a fixed 30 degrees to 40 degrees of flexion. X appeared to have mostly joint stiffness with some contribution of stiffness from X extensor tendon. X had reached a plateau with the index finger with therapy. X was to advised to continue to work with occupational therapy and was okay for all activities and devices as appropriate and tolerated. X was to return to the clinic in X for a X with a plan to X on X for X. Per the X visit

note by X, PA, X presented for routine follow-up. X had completed X prior available occupational therapy sessions. X continued home exercise program and reported X had not made any additional progress with index or middle finger range of motion, but had maintained ongoing range of motion and scar massage / moisturizing. X reported persistent edema to the fingers in the morning that improved throughout the day with elevation and movement. X was otherwise well. Right upper extremity examination revealed well-healed scars to the index and middle fingers; soft and pliable tissue; normal alignment with no malrotation at rest. The index finger PIP was fixed in flexion from 30-40 degrees, equal active and passive range of motion and DIP joint held in moderate flexion (stable) was noted. Middle finger PIP joint was with 20 degrees of extensor lag, active flexion to 90 degrees, passive to 95 degrees. Sensation is intact to light touch throughout the distal distributions of the median, radial, and ulnar nerves. The hand was well-perfused. X-rays of the right fingers demonstrated surgical fixation of the proximal phalangeal head second digit, with near-complete healing. There was an anchor screw noted through the distal base of the middle phalanx third digit. Moderate arthritis erosive changes were seen at the second DIP joint. The diagnosis was right finger stiffness. X noted X had made some progress with range of motion with therapy, and could get X middle finger tip to the palm after therapy sessions; however, X index finger remained significantly stiff with limited range of motion at the PIP joint with a range of motion arc limited from a fixed 30 degrees to 40 degrees of flexion. X appeared to have mostly joint stiffness with some contribution of stiffness from X extensor tendon. X had reached a plateau with the index finger with therapy. The plan was to proceed with X. X was provided to X. X was to X as well.

X-rays of the right fingers dated X, demonstrated surgical fixation of the proximal phalangeal head second digit, with near-complete healing. There was an anchor screw noted through the distal base of the middle phalanx third digit. Moderate arthritis erosive changes were seen at the second DIP joint.

Treatment to date included X.

Per a reconsideration review adverse determination letter dated X, the appeal

request for X was denied by X, MD. Rationale: "The Official Disability Guidelines states that X. The Official Disability Guidelines does not provide specific recommendations for X. X state that X can be considered when a patient does not respond to a period of non-operative treatment. X et. X state that X for digital stiffness after hand fractures can offer improvements in finger motion. To achieve a successful outcome, the surgeon must X to maximize intraoperative motion and must X. The request for X was previously denied as the X is not recommended for proximal interphalangeal extension contracture. The request is not supported in full without a successful peer to peer discussion to discuss a modified treatment plan. The provider submitted an appeal as the claimant is still experiencing right index finger stiffness and requires X. In this case, the claimant underwent open reduction and internal fixation (ORIF) of intra-articular right index finger proximal phalanx fracture, ORIF of intra-articular right middle finger middle phalanx fracture, repair of right middle finger central slip, repair of right middle finger radial collateral ligament, and simple repair of palm laceration, X on X. They had made some progress with therapy with the middle finger, but the index finger remains significantly stiff with limited range of motion at the PIP joint fixed in flexion from 30-40 degrees. X-ray revealed well healed fractures, index finger with adequate joint space at PIP joint, screws potentially protruding into lateral bands. While surgical intervention with X would be beneficial given persistent stiffness in the right index finger despite completion of occupational therapy, the guidelines do not support X due to limited evidence of long-term efficacy. The request is not supported in full, and partial approvals are not allowed without a peer-to-peer discussion and agreement. As such, the request for X is non-certified. Peer to peer was unsuccessful. Because an adverse determination for surgery has been rendered, an adverse determination for any associated pre-operative clearance is also rendered."

The requested X is medically necessary and appropriate. The previous reviewer indicated that a X was to occur. However, it does not appear that this is being requested with this review. The record reflect that the claimant has limited flexion of the index finger PIP joint and unable to make a complete fist. The record reflect that the claimant has plateaued in overall recovery with therapy. The arc of motion

is 30 to 40 degrees of flexion. They records also reflect that the hardware may be impinging upon the lateral bands. Thus, X. The requested X is supported by the medical records. X is medically necessary and certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The requested X is medically necessary and appropriate. The previous reviewer indicated that X was to occur. However, it does not appear that this is being requested with this review. The record reflect that the claimant has limited flexion of the index finger PIP joint and unable to make a complete fist. The record reflect that the claimant has plateaued in overall recovery with therapy. The arc of motion is 30 to 40 degrees of flexion. They records also reflect that X. Thus, the X would be indicated. The requested procedure consisting of X is supported by the medical records. X is medically necessary and certified.

Overturned

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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