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## Notice of Independent Review Decision

**DATE NOTICE SENT TO ALL PARTIES:** 12/27/13

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of ankle (E1816).

**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 Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

**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 - ankle (E1816).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed: 10/4/13 UR worksheet, 10/9/13 denial letter, 9/27/13 authorization request, 5/16/13 detailed written order, 10/24/13 UR worksheet, 11/5/13 report, 11/6/13 denial letter, 10/24/13 letter, 10/9/13 denial letter, 11/27/12 to 12/18/12 office notes, operative report 3/1/13, 3/29/12 initial PT eval report, 9/4/13 to 9/26/13 PT treatment encounter notes, 5/23/13 approval letter, 6/27/13 approval letter, SPS section of ODG, and 6/22/11 product description for SPS.

A copy of the ODG was provided by the Carrier/URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient sustained a bi-malleolar ankle fracture/open right ankle fracture-dislocation while playing basketball. Treatment included ORIF, ORIF/external fixator revision and removal and extensive PT. Improved motion includes dorsiflexion to -7. Appeal letter dated 10/24/13 (noting the device was received in 5/13) and denial note dated 11/5/13 were reviewed. Denials noted the lack of progress note reference to the device use and/or outcomes specifically associated with the device.

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

The reviewer notes that without specific detailed progress notes evidencing positive outcomes specifically attributable to the device, along with applicable ODG criteria not recommending dynamic splinting "at all in the management of joint injuries of the ankle"; the request cannot be considered reasonable or medically necessary. The rationale utilized in the prior denials is applicable and the denials are hereby supported at this time.

Reference: ODG Ankle (and knee) Chapters. Static progressive stretch (SPS) therapy, recommended as indicated below. Static progressive stretch (SPS) therapy uses mechanical devices for joint stiffness and contracture to be worn across a stiff or contracted joint and provide incremented tension in order to increase range of motion. Dynamic splinting devices for the knee, elbow, wrist or finger are recommended as an adjunct to physical therapy with documented signs of significant motion stiffness/loss in the sub-acute injury or post-operative period (i.e., at least 3 weeks after injury or surgery), or in the acute post-operative period with a prior documented history of motion stiffness/loss in a joint along with additional surgery done to improve motion to that joint. Prophylactic use of dynamic splinting is not recommended, and dynamic splinting is not recommended at all in the management of joint injuries of the shoulder, ankle and toe, or for carpal tunnel syndrome. Static progressive stretching devices may be an effective method for increasing the ranges of motion and satisfaction levels of patients who develop arthrofibrosis after total knee arthroplasty.

Criteria for the use of static progressive stretch (SPS) therapy:

A mechanical device for joint stiffness or contracture may be considered appropriate for up to eight weeks when used for one of the following conditions:

1. Joint stiffness caused by immobilization.
2. Established contractures when passive ROM is restricted.
3. Healing soft tissue that can benefit from constant low-intensity tension. Appropriate candidates include patients with connective tissue changes (e.g.,

tendons, ligaments) as a result of traumatic and non-traumatic conditions or immobilization, causing limited joint range of motion, including total knee replacement, ACL reconstruction, fractures, & adhesive capsulitis.

4. Used as an adjunct to physical therapy within 3 weeks of manipulation or surgery performed to improve range of motion

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