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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX

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

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

PATIENT CLINICAL HISTORY [SUMMARY]: XXXX. XXXX was diagnosed with unspecified injury of the XX XX, XX and XX(XX), subsequent encounter, pain in the XX XX, weakness, XX, XX or XX, injury of the XX XX, unspecified dislocation of the XX, XX wound of the XX, open XX XX of the XX XX of the XX XX XX, XX, XX XX of the XX XX XX with XX involvement, XX of the XX XX of the XX, XX of the XX XX XX of the XX XX, XX XX XX XX, and XX XX of the XX. On XXXX, an unknown therapist / XXXX evaluated XXXX for XX of custom XX XX XX XX for XX XX and XX. XXXX had pain in the XX XX XX, ranged from XX/10 at rest up to XX/10 if not elevated or any motion. XXXX had XX, XX, and XX if not elevated. XXXX demonstrated moderate XX XX with the XX XX XX (XX XX: XX.XX cm; XX: XX.XX cm; and XX: XX.XX cm) compared to the XX (XX: XX.XX cm; XX XX (XX): XX.XX cm; and XX: XX.XX cm). XXXX had no light touch sensation over the XX of the XX XX XX but felt pressure. XXXX wound did not appear XX, but XXXX did have superficial XX XX, which was most likely due to early XX loss directly post injury. The XX active range of motion (XX) of the XX XX was XX degrees to flexion and extension. There was XX of the XX. The XX XX of the XX XX joint was XX degrees for flexion and XX degrees for extension. The XX XX of the XX XX joint for extension was XX degrees and 0 degrees for the extension passive range of motion (XX). XXXX had an active extension of XX joint but limited due to the moderate XX but had passive motion up to XX degrees extension. This should improve in the upcoming few days as XX decreased and XXXX performed active extension exercises within the confines

of XX. As rehabilitation progressed, XXXX might need individual XX extension XX or relative motion XX to improve XX active extension with XX or XX bands to terminal XX XX at XX. XX problem list included activities of daily living limitations; decreased coordination, motor control, and skin integrity; impaired range of motion, sensation, and strength; increased XX, XX dysfunction, and work limitations. An x-ray of the XX XX dated XXXX showed persistent XX dislocation of the small XX XX joint with associated fracture at the XX XX XX. The treatment to date included medications (XXXX), exercise, XX, and surgery consisting of XX XX with XX XX (XX) of the XX XX XX, XX, and XX XX XX repair, XX slip XX mechanism repair, XX XX repair, and radial XX repair / XX XX of the XX XX on XXXX. Per a utilization review decision letter and peer review dated XXXX, the request for XX therapy XX times per week for XX weeks (XX visits) for the XX XX, XX, and XX XX with expected start date XXXX was denied. Rationale: "XX is not approved per ODG. The patient should be re-evaluated before XX sessions are done. The doctor was not available to modify the request. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request for XX therapy XX times a week times XX weeks XX XX, XX XX and XX XX XX XX times XX; XX, XX, XX, XX, XX times XX; XX, XX, XX, XX times XX and XX is non-certified." Per a reconsideration review decision letter and peer review dated XXXX, the appeal for XX therapy XX times per week for XX weeks (XX visits) for the XX XX, XX, and XX XX with expected start date XXXX was not approved. Rationale: "With the total amount of XX therapy not documented and with XX codes XX, XX not supported by ODG and with this being a XX case that cannot be modified without a case discussion agreement. There is no support for the requested appeal XX therapy XX times a week for XX weeks XX XX, XX XX and XX XX XX XX, times XX; XX, XX, XX, XX, XX, times XX; XX, XX, XX, XX, times XX; and XX as being medically necessary. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request for appeal XX therapy XX times a week for XX weeks XX XX, XX XX and XX XX XX XX, times XX XX, XX, XX, XX, XX, times XX XX, XX, XX, XX, times XX XX is upheld."

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

The ODG recommends up to XX visits of XX therapy following surgery for XX fractures. The ODG does not support electrical stimulation (XX, XX), therapeutic ultrasound (XX), or whirlpool therapy (XX). The ODG does not recommend paraffin wax baths (XX) for the provided diagnoses. The available information indicates that an XX therapy assessment was completed on XXXX, but it is unclear if any therapy was performed following the initial evaluation. Given the lack of documentation regarding the total amount of XX therapy completed, the medical necessity of the requested XX visits of XX therapy cannot be established. In addition, several of the requested CPT codes are not supported.

Based on the provided documentation, medical necessity has not been established.

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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
☐ MILLIMAN CARE GUIDELINES
☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
☐ TEXAS TACADA GUIDELINES
☐ TMF SCREENING CRITERIA MANUAL

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