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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX XX XX (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 found to have a XX XX XX XX XX and XX XX XX XX XX. XXXX was evaluated by XXXX for a postoperative visit. XXXX had XX XX XX reconstruction using XX XX and partial XX XX done on XXXX. XXXX stated XXXX had significant improvement from the injection of the XX XX on the prior visit. XXXX had a diagnosis of XX XX and XX XX XX since the previous visit and was on XXXX. On examination, the incision was healing well with no signs of infection or XX. The XX XX were well approximated, and there was no visible XX XX. There was no tenderness or swelling. The range of motion and strength were progressing as expected. The neurovascular examination was XX. The plan was to restart XX therapy. Measurements for XX XX ligament (XX) XX XX were taken. XXXX noted XXXX was okay to return to work on light duty through XXXX. Per a XX XX-XX, the restrictions would include no kneeling / squatting, bending / stooping, pushing / pulling, twisting, climbing stairs / ladders, or running; no walking for more than XX hours per day; and no sitting, grasping / squeezing, XX flexion / extension, reaching, overhead reaching, or XX for more than XX hours a day. XXXX was not to lift / carry more than XX pounds. On XXXX completed a prescription and statement of medical necessity for XX XX and ordered a custom XX XX ligament XX for the XX XX XX, noting that XXXX had XX and XX due to XX XX or reconstruction and a custom XX XX XX XX was needed for daily living. XXXX underwent a XX therapy visit on XXXX for generalized

XX XX, pain in the XX XX, and stiffness of the XX XX. The medical diagnosis was XX of XX XX ligament of the XX XX, subsequent encounter. XXXX had been seen at the clinic for therapy services from XXXX. XXXX was progressing well; however, XXXX was slightly behind where expected XX months postoperative to address XX XX XX / XX XX. XXXX needed to continue to develop XX activation and gross XX XX XX strength especially eccentric control to return to active lifestyle. XXXX had impaired performance in functional movements including normal ambulation without aid and also with decreased flexion and range of motion were restricted. The interventions included group therapy, neuromuscular re-education, manual therapy, functional activities, therapeutic exercise, gait training, self-care / home management training, physical performance test, low complex patient evaluation, and electrical stimulation. An MRI of the XX XX performed on XXXX demonstrated complete XX XX XX XX, grade XX XX XX XX XX, XX XX XX XX and XX XX without XX tear, minimal XX XX fracture in the XX XX XX with associated XX XX, XX XX XX in the XX and XX XX plateaus, and XX joint X. Treatment to date included medications (XXXX), XX tendon region injection, surgery (XX XX ligament reconstruction and XX XX repair), and XX therapy with progress. Per a utilization review decision letter dated XXXX, the requested service of XX XX ligament XX XX (XX) (XX) was not certified. Determination: "The ODG does not support the use of postoperative XX XX, as there are no high-quality studies to support its use. The current clinical documentation indicates that the patient underwent an XX XX. There are no exceptional factors documented, indicating the need for an XX XX. Given the lack of support for the use of an XX XX by the ODG, the requested XX XX would be considered not medically necessary. The request is recommended for noncertification." Per a reconsideration adverse determination letter dated XXXX, the requested service of XX XX XX XX XX (XX) was not certified. Determination: "XX The clinical documentation provided indicates that the injured worker had a XX XX XX XX on XXXX. A recent physical examination does not indicate any ongoing XX and indicates that the XX XX is progressing with a range of motion and strength. Based on the documentation provided, the XX XX does not meet ODG criteria for a custom XX XX XX as there is no documented XX XX XX, skin changes, osteoarthritis, offloading of a specific compartment, or severe instability on physical examination. The additional information obtained during the peer to peer conversation would not support custom bracing. The request is recommended for noncertification."

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

Based on the clinical information provided, the request for XX - XX XX ligament (XX) XX XX is not recommended as medically necessary. There is insufficient information to support a change in determination/prior denials. The submitted clinical records fail to establish that the patient presents with a condition for which the Official Disability Guidelines would support a custom XX XX. There is no documentation of abnormal XX contour, XX changes, severe XX, maximal off-loading of painful or repaired XX compartment or severe instability as noted on physical examination of the XX.

Therefore, medical necessity is not established in accordance with current evidence-based guidelines and the decision is upheld.

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