MEDRX

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DATE OF REVIEW: September 5, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

XX unit following XX ankle XX repair with XX XX XX tendon XX

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.

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 medical necessity of: XX unit following XX ankle XX repair with XX XX XX tendon repair

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a XXXX who sustained an XX injury on XXXX. Injury occurred when XXXX. As XXXX, XXXX felt a XX sensation to XXXX XX foot. A review of records documented conservative treatment to include physical therapy, activity modification, multiple injections, bracing, ice, and medications. Social history indicated that the patient was a

XX XX. Past medical history was positive for XX and XX. Past surgical history was reported positive for XX surgery. XXXX had no known XX XX. The XXXX XX foot MRI impression documented XX and XX of the XX XX at the XX XX XX XX. The XX XX XX complex was unremarkable. The XXXX XX ankle MRI impression documented XX XX ligament sprain and distal tibiofibular joint posterior tibiofibular ligament and interosseous ligament or XX XX sprain, XX ankle XX XX, XX XX of the XX XX with XX XX of the XX XX XX XX XX XX XX with XX, and XX XX syndrome with XX. There was medial XX XX XX sprain with XX of the XX XX ligament XX XX XX and XX XX, and XX XX and XX XX XX XX at the XX XX XX. The XXXX XX chart notes documented that XX ankle/XX x-rays demonstrated XX ankle XX with XX of the XX joint with noted XX-XX XX. A diagnostic ultrasound of the XX foot revealed findings consistent with XX and XX in the XX XX tendon XX to the XX XX. The XXXX podiatry chart notes documented subjective complaints of XX grade XX-XX/10 XX foot and XX ankle pain with associated XX, XX, XX, XX/XX, XX/XX, XX, XX, and XX. It was noted that the patient was seen for XX foot/XX follow-up. XXXX still had some XX, XX and XX. XXXX noted that the injection helped and would like another one if possible. Symptoms were aggravated by standing, walking, weight bearing, getting out of bed, going from sit to stand, going up and down stairs, and exercise. XX ankle/XX exam documented both XX and XX XX, XX XX XX, tenderness over the XX ankle, XX ankle, and XX XX XX XX, and tenderness of the XX XX and XX, XX XX, XX XX ligament, XX ligament, and XX XX. There was diminished range of motion secondary to guarding. There was XX/XX XX XX and XX XX. There was pain and instability with XX XX test, XX XX pain and instability, and XX XX ligament complex. The diagnosis included XX XX ligament sprain, XX XX XX, XX foot sprain, and XX foot and XX joint pain. The treatment plan documented a discussion of conservative and surgical treatment options. It was noted that the patient had a twofold problem of XX instability and XX XX XX. XXXX required a XX XX and XX XX XX. The XXXX XX (XX XX XX) certification form indicated that the risk factors for this patient included age XX-XX years, history of XX XX XX, XX XX, compression of XX, XX XX XX or XX, use of XX, and general anesthesia greater than XX minutes. It was noted that the patient had a higher risk of developing XX XX (XX) due to the type of surgery performed, combined with other XX XX. A XX XX device with XX XX leg XX XX (XX and XX), and necessary appliances was prescribed for XX XX. The XXXX peer reviewer determination non-certified the request for XX ankle XX XX with XX XX XX tendon repair as guideline criteria had not been met. The XXXX peer review determination non-certified the associated surgical request for XX unit purchase as the associated request for XX ankle XX repair with XX XX XX tendon XX had been recommended for non-certification. The XXXX podiatric chart notes stated that the patient had documented instability with positive XX XX and XX XX. XXXX had XX XX, therapy and medication. Injection had given the patient relief both along the XX XX ligament and XX XX. There was clear documentation from both the occupational medicine clinic and podiatry notes indicating failed bracing which

was not effective in the patient's instability and pain XX. MRI demonstrated XX ankle XX and XX XX pathology including XX XX pathology. XXXX was not working. Given the current findings and appropriate documentation, this surgery should be certified given findings and ODG criteria being met and documented. The XXXX peer review determination non-certified the request for XX ankle XX XX with XX XX XX tendon XX as guideline criteria had not been met. The XXXX peer review determination non-certified the associated surgical request for XX unit XX. The rationale indicated that the request for XX ankle XX XX with XX XX XX XX repair was not considered to be medically necessary. Without approval of the requested surgical intervention for the XX ankle, the need for XX unit was not medically necessary.

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

The prospective request for XX unit following XX ankle XX XX with XX XX XX tendon XX is not medically necessary. The denial is upheld.

The Official Disability Guidelines recommend identifying subjects who are at a high risk of developing XX XX and providing prophylactic measures such as consideration for anticoagulation therapy. Guidelines state that a retrospective study of > 7,000 podiatry patients identified a low overall risk of XX XX (XX) in podiatric surgery, suggesting that routine XX is not warranted. For patients undergoing a podiatric procedure with a history of XX, the risk for a procedure-related XX increases significantly and XX XX is recommended. The ODG generally recommends XX XX XX prophylaxis for patients who are at higher risk of developing XX XX undergoing knee and leg surgeries. Options include prophylactic measures such as low XX XX XX (XX) and newer, longer-duration direct oral anticoagulation agents (referred to as DOACs or Factor XX inhibitors), as well as perioperative (hospital only) leg compression devices.

This patient presents with persistent XX XX ankle/XX pain with associated XX, XX, XX, and XX. XXXX has been recommended for XX ankle XX repair with XX XX XX tendon XX. Under consideration is an associated surgical request for home XX unit for prophylaxis. Guideline criteria have not been met. This patient has XX risk factors documented. There is no documentation that XX therapy would be contraindicated, or standard XX XX insufficient, to warrant the use of mechanical prophylaxis beyond the peri-operative period. Additionally, the associated surgical procedure has not been found to be medically necessary. There is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception to guidelines. Therefore, this request for a XX XX unit 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**
☐ **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**

ODG Treatment
Integrated Treatment/Disability Duration Guidelines
Ankle and Foot
(Updated 8/24/2018)
XX XX

ODG Treatment
Integrated Treatment/Disability Duration Guidelines
Knee and Leg
(Updated 7/6/2018)
XX XX XX XX

☐ **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)**