CASEREVIEW
8017 Sitka Street
Fort Worth, TX 76137
Phone: 817-226-6328
Fax: 817-612-6558

October 22, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX Ankle Foot XX: New XX Articulating

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a Board Orthopedic Surgeon with over 18 years of experience.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX who sustained a work injury in XXXX. XXXX was wearing a short height XX-X with XX and XX stop to limit/prevent supination during weight bearing and ambulation. A new XX was order due to the current one being XXXX years old.

On XXXX, the claimant presented to XXXX, XX for excessive pressure on XXXX great toe. To resolve this issue, they heat flared the XX XX section of the plastic and trimmed the proximal brim. The claimant reported immediate relief after adjustments.

On XXXX, the claimant presented to XXXX, XX for fit and delivery of XX ankle foot XX. They lined the XX with XX. The brace was fitting and functioning appropriately. All goals were met.

On XXXX, the claimant presented to XXXX for a XXXX medication management follow up. XXXX continued to have XX pain radiating into the XX/XX calf. XXXX had continued hypersensitivity at the XX XX leg intermittently. XXXX continued to ambulate with a XX XX. XXXX had been using XXXX. Overall, XXXX pain management regimen was helpful.

On XXXX, the claimant presented to XXXX for a XXXX medication management follow up.

XXXX continued to have neuropathic pain radiating into the XX/XX calf. XXXX had continued hypersensitivity at the XX XX leg intermittently. XXXX continued to ambulate with a XX XX. The XX is nearing XXXX years old and was in need of being replaced. XXXX had been using XXXX. Overall, XXXX pain management regimen was helpful. XXXX does experience problems with balance related to the XX XX extremity and had a cane but was not using it routinely. A new XX, custom-fabricated molded articulating was ordered.

On XXXX performed a UR. Rationale for Denial: The proposed treatment consisting of XX Ankle Foot XX New Custom-Fabricated Molded Articulating (Ankle foot XX, plastic with ankle joint, custom-fabricated #1, Addition to XX extremity, limited ankle motion, each joint #1, Addition to XX extremity, varus/valgus correction, plastic modification, padded/lined #1, Addition to XX extremity XX, soft interface for molded plastic, below knee section #1) purchase is not appropriate and medically necessary for this diagnosis and clinical findings. The injury is nearly XXXX. Diagnosis is neuropathic pain XX XX extremity. The most current MD note provided for my review is from XXXX. Request is for custom ankle/foot XX. However, according to ODG, XX is "Recommended as an option for foot XX. An ankle foot XX (XX) also is used during surgical or neurologic recovery." Given the clinical information provided, diagnosis, exam findings and complaints, this request is not medically necessary.

On XXXX performed a UR. Rationale for Denial: Per ODG (XX), Ankle and Foot Chapter, "An ankle foot XX (XX) also is used during surgical or neurologic recovery. "Based on the extremely chronic nature of the condition, the fact that the notes show that the claimant has a XX XX already, and lack of any discussion of non-functionality of current XXXX year old XX), the request is not medically necessary at this time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The request for a new ankle foot XX (XX) is not medically necessary at this time.

This patient sustained a XXXX. XXXX has neuropathic pain and hypersensitivity in XXXX XX XX leg. XXXX is responding well to XXXX current pain management regimen. XXXX uses a XX leg XX to limit/prevent supination during weight bearing and ambulation. The treating provider has recommended a new XX for this patient.

The patient has a brace that is XXXX years old. There are no documented issues with the current XX. If there is a problem with this brace, the XX can be adjusted by an orthotist before a replacement is considered. A new XX is not medically necessary for this patient.

PER ODG:

Ankle foot XX (XX)
Body system:
Ankle and Foot
Treatment type:
Orthotics
Related Topics:
See also IDEO™ (intrepid dynamic exoskeletal XX).

Conditionally Recommended CR

Recommended as an option for foot XX. An ankle foot XX (XX) also is used during surgical or neurologic recovery.

Evidence Summary

The specific purpose of an XX is to provide toe dorsiflexion during the swing phase, XX and/or XX stability at the ankle during stance, and, if necessary, push-off stimulation during the late stance phase. An XX is helpful only if the foot can achieve plantigrade position when standing. Any equinus contracture prohibits its successful use. The most commonly used XX in foot XX is constructed of polypropylene and inserts into a shoe. If it is trimmed to fit anterior to the malleoli, it provides rigid immobilization. This is used when ankle instability or spasticity is problematic, such as in patients with upper motor neuron diseases or stroke. If the XX fits XX to the malleoli (XX leaf spring type), plantar flexion at heel strike is allowed, and push-off returns the foot to neutral for the swing phase. This provides dorsiflexion assistance in instances of flaccid or mild spastic equinovarus deformity. A shoe-clasp XX that attaches directly to the heel counter of the shoe also may be used. (Geboers, 2002)

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)**