

# **CASEREVIEW**

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

Outpatient Surgery: XX

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

This physician is a Board Certified Orthopedic Surgeon with over 16 years of experience.

## **REVIEW OUTCOME:**

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

Partially Overturned (Agree in part/Disagree in part)

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 injuries in an XXXX. XXXX has been under the care of XXXX for XX.

On XXXX, the claimant presented to XXXX with XX XX swelling, weakness and limited ROM after prolonged standing. On examination, XX XX were removed. XXXX was ambulating without assistance. XXXX had limited ROM of the XX XX. Plan: Continue physical therapy. If continued XX, obtain CT scan.

On XXXX the claimant presented to XXXX with continued complaints of XX XX swelling

and limited ROM. Plan: Refer to XXXX and CT of the XX XX.

On XXXX XX XX CT Scan Impression: 1. Unchanged, XX XX of an XX XX at the base of the XX XX XX with XX XX XX. 2. Unchanged, healed, reduced and internally fixated XX of the XX XX XX. 3. Healed, comminuted, nondisplaced, XX-XX fracture XX involving the XX XX with fracture extension as the XX XX XX, but no XX surface XX. 4. Persistent mild XX/XX XX of the XX XX with respect to the XX along the XX XX of the XX XX consistent with developing mild XX XX XX XX. 5. XX XX XX XX. 6. Redemonstration of XX XX XX.

On XXXX the claimant presented to XXXX with XX XX stiffness and XX pain. On examination there were XX XX reconstructions and XX XX more in the proximal aspect of the XX and XX not extending into the XX XX. There was mild tenderness at the base of the XX XX. XX was about XX degrees shy of XX. With XX of the XX, XXXX Achilles tendon did appear to be somewhat taut, however, it was not tight. XXXX had weaker XX XX on the XX. XXXX was able to do a XX XX XX with assistance and was weaker on the XX. Plan: XX XX with XX of the XX formation XX in the XX XX was discussed. Also lengthening of XXXX Achilles tendon as well as releasing of the XX XX of the XX. The application of a XX XX XX and ex-fix to slowly bring XXXX ankle up to appropriate amount of XX was also discussed.

On XXXX performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is not certified due to the guidelines do not support XX for treatment of XX or XX and a CT scan reported the XX XX fracture was healed.

On XXXX performed a UR. Rationale for Denial: Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is non-certified. This is an appeal of a previous denial which noted lack of objective findings to support further surgery. The claimant's CT studies did note the development of post-traumatic XX XX. The claimant's previous fractures had healed. The XXXX clinical report noted some loss of range of motion and mild weakness. However, there were no other significant findings noted to support further surgical intervention at this point. It is unclear how additional surgery would result in functional improvement for the claimant's current condition.

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

The request for XX XX versus XX XX and application of XX XX XX is approved, in part.

This patient sustained a XX XX fracture as a result of a XXXX. XXXX XX XX XX is limited to XX (XX XX on XX). XXXX has pain at XX XX of the XX XX. This limitation prevents XXXX from XXXX. The treating physician identified an XX XX, which XXXX feels is a mechanical block to XX and should be removed surgically. XXXX has also recommended XX of the XX XX and XX capsule release, followed by application of a XX XX XX to achieve full XX.

Removal of the XX XX, performed either open or XX, is medically necessary for this patient. If XXXX does not have adequate XX following this procedure, XX releases and XX XX XX would be reasonable for this patient at the time of surgery. Aggressive physical therapy following this procedure should allow for sufficient XX to allow this patient to return to XXXX work as a XXXX

This patient requires a small correction in XX. The XX XX XX should be reserved for a more significant XX. It is not medically necessary in this case.

The XX XX and XX XX XX are only found to be medically necessary and are approved for this patient.

#### **PER ODG:**



XX utilizes an optical scope connected to a camera, allowing clear visualization of the XX of a XX, often allowing performance of surgery through tiny incisions, resulting in faster and easier recovery.

#### *Evidence Summary*

Originating as a diagnostic-only tool, XX XX has become a valuable procedure for treatment of various XX problems. (Stufkens, 2009) XX XX provides a minimally invasive treatment option for a wide variety of indications including XX, XX defects, XX XX, XX, XX, XX, and XX. XX XX pathology can be treated using XX XX XX. XX compares favorably with open surgery having less morbidity and a quicker recovery. (de Leeuw, 2009)

Fair evidence supports the use of XX XX for the treatment of XX XX, XX lesions, and to assist XX XX. XX XX for instability, XX XX, XX, and removal of XX XX is supported with only poorer-quality evidence. Except for a XX, treatment of XX XX, excluding isolated XX XX, is ineffective and therefore not recommended. There is insufficient evidence to support or refute benefits of XX for XX and fractures. (Glazebrook, 2009)

#### **Open reduction internal fixation (ORIF)**

Body system:

XX and XX

Treatment type:

Implants, Surgery

## Conditionally Recommended CR

Recommended as an option for fractures when radiographic evidence indicates a displaced fracture or comminuted fracture, or an open fracture with bone protrusion.

### *Evidence Summary*

Open XX XX XX (XX) is a method of surgically repairing a fractured bone, in which surgery is used to reduce or set the fracture fragments and then hardware (such as a rod, plate and/or nails) is then implanted to hold the reduction in place. ([Lange, 2007](#))

#### **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)**