Date notice sent to all parties: 2/5/2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of inpatient surgery for a XX with XX, other XX, XX, and XX with or without internal fixation of the 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 disagrees with the previous adverse determination regarding the prospective medical necessity of inpatient surgery for a XX with XX, other XX, XX, and XX with or without internal fixation of the XX.

PATIENT CLINICAL HISTORY [SUMMARY]:
This patient is a XX-year-old XX who sustained an XX injury on XX. The mechanism of injury was described as XX of XX when XX felt XX in XX XX XX with XX of XX and XX. Past medical history was positive for XX. Social history was positive for XX. XX was diagnosed with XX XX sprain and XX XX traumatic XX.

On XX, XX presented with signs/symptoms of severe XX and was diagnosed with XX and XX of the XX, XX of the XX XX with XX, and XX with early acute XX. XX was admitted to the intensive care unit. XX underwent XX for treatment of XX, XX, incision and drainage of XX, and XX on XX and underwent subsequent irrigation and debridement procedures on XX and XX. On XX, XX underwent

irrigation, debridement, XX, and XX transfer. XX was diagnosed with XX on XX. On-going XX management and XX therapy were noted through XX.

An electrodiagnostic on XX demonstrated severe XX median XX at the XX, and prolongation of the XX XX aspect of the XX likely secondary to XX. The XX XX was no evaluated on the XX due to XX of the XX and XX digits.

The XX operative report indicated that the patient had lost all function of the XX/XX/XX/XX due to severe pain and had failed conservative treatment. XX underwent repair of the XX at the XX XX, full thickness XX for wound coverage, repair of the XX of the XX, tissue rearrangement for wound coverage, repair of the XX with XX, XX of the XX tear, tendon transfer to the XX, and fusion of the XX with auto XX.

The XX operative report indicated that the patient was diagnosed with XX failure, XX, and XX XX injury. XX underwent XX removal, XX with XX, XX of the XX XX joint without XX XX, and placement of new hardware.

The XX XX surgeon report indicated that the patient had been doing very well, but recently had some tenderness at the drain sites. XX XX extremity exam documented XX XX in place and XX and viable. There were no signs of infection. Range of motion was limited due to hardware placed for fusion. Sensation and circulation were good. There was mild tenderness at the drain sites with no signs of complex XX. XX XX exam documented the XX in place and fusion healing well. The treatment plan recommended removal of all XX, continued XX, and XX injection to the drain site. Medications and vitamins were prescribed to assist with tissue, nerve and wound healing and for XX against complex XX.

The XX XX surgeon report indicated that the patient was XX weeks post XX XX surgery. Current complaints included severe contraction of XX XX middle XX making it difficult for XX to use XX XX and XX XX. XX would like for XX middle XX to improve. XX XX exam documented middle XX XX joint due to XX and XX, tenderness, XX, decreased range of motion, guarding, weakness/XX. XX had XX and XX tendon injuries and was unable to make a fist or extend the XX. The diagnosis included XX XX XX joint contracture. The treatment plan recommended XX XX with microsurgery, other XX XX, open treatment of XX (XX) joint dislocation with or without XX or XX. The patient would need to stay overnight at the hospital.

The XX utilization review report denied the request for inpatient XX XX XX XX XX with microsurgery. The rationale stated that XX XX substitutes were not recommended per the Official Disability Guidelines as there was inadequate objective clinical evidence to support the use of XX XX chips or other XX XX, XX, XX to enhance or replace the god standard of XX. It was noted that the exact procedure being requested was not explained and supporting documentation not provided. The XX interpretation of the XX images reported no abnormalities of

the middle XX that required the requested surgical procedures. The patient's injury was chronic and so the request for open reduction and internal fixation of a XX fracture with a contracture was unclear and not supported. Additionally, the request for a XX XX requiring XX was unclear and inpatient admission was not supported.

The XX XX surgeon report indicated that the patient was ready for middle XX surgery. XX complained of severe middle XX contraction making it difficult to use the XX or XX XX. XX XX exam was unchanged from XX. XX XX demonstrated previous XXof the XX aspect of the XX/XX. The treatment plan recommended XX XX with microsurgery, other XX XX, open treatment of XX (XX) joint dislocation with or without internal or external fixation. The patient would need to stay overnight at the hospital.

The XX utilization review report denied the appeal request for inpatient surgery, XX XX with microsurgery, other XX XX, XX, and XX joint with or without internal fixation of the XX XX XX. The rationale stated that the patient was indicated for XX XX for correction of the XX, but the requested XX XX XX was not indicated.

The XX XX surgeon appeal indicated that the patient had multiple surgeries performed by another surgeon after XX sustained trauma to the XX XX extremity. XX had XX of the XX XX extremity and underwent extensive debridement of the XX XX extremity with removal of XX, XX, XX, XX, XX tissues. XX had XX of the XX and XX XX to the base of the XX, and a large section of the XX of XX XX, XX, and XX removed due to salvage of XX XX extremity from the XX XX. XX had XX placed and had acquired contractures of the XX XX extremity due to XX and XX. XX was told by other surgeons that XX only option was XX. The XX surgeon indicated that he had performed two surgeries and had been successful in improving XX XX and XX contractures and repairing XX tendons and soft tissues. XX now had function of the XX and XX. XX only had XX XX and XX XX functioning at this time. The XX middle XX had severe contracture, XX deformity, and scarring with XX XX, and was contracted into the XX. The goal of treatment was to improve the anatomy of the XX XX where it could be used to help with XX function with use of the XX and XX XX. XX needed to undergo removal of the XX XX XX and contracted XX XX which would cause shortening of the XX and poor function. Therefore, XX would undergo XX. The XX would come from the remnant of the XX previous XX of the XX little XX. This XX would allow for repair of the XX/contracture/wound closure which would allow the patient to keep the XX of the XX to allow function compatible with the XX and XX XX. XX XX XX exam documented the XX XX was contracted into the XX with severe XX of the XX and XX and XX XX. XX of the XX XX, XX, and XX demonstrated previous traumatic XX of the XX aspect of the XX/XX and XX XX XX XX with contracture into the XX. The treatment plan recommended surgery to include XX XX with microsurgery, other XX XX, and XX, XX, with or without internal fixation. The patient would need to stay overnight in the hospital in order to monitor XX, XX are inpatient procedures.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The Official Disability Guidelines (ODG) XX.

The ODG recommend the best practice target length of stay (LOS) for cases with no complications. Alternatively, recommend the median LOS based on type of surgery if best practice data are not available. Guidelines do not specifically address this surgical procedure in the length of stay guidelines, but best practice target length of stay of one-day and median length of stay of XX days for XX open reduction and internal fixation which would be a comparable surgery.

This patient presents status post XX XX XX injury due to XX of the XX XX extremity. XX is status post XX of the XX XX and XX XX and a large section of the XX aspect of XX XX, XX, and XX. XX has the use of the XX XX and XX XX, but the XX XX is contracted into the XX and makes use of the XX and XX XX difficult. Clinical findings and XX studies have documented severe XX XX XX and contracture. XX has failed long-term conservative treatment, including medications, XX, and therapy. The XX surgeon has recommended microsurgical reconstructive surgery for the XX XX using a XX from the residual XX to provide length and functionality with the XX and XX XX. There is no evidence that a XX XX substitute would be utilized. Additionally, inpatient admission is warranted based on the patient's complex history and neurovascular monitoring of the flap, and is supported by the guidelines. Therefore, the prospective request for inpatient surgery for a XX XX with microsurgery, other XX XX, XX, and XX with or without internal fixation of the XX middle XX is 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**

☐ **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)**