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Notice of Independent Review Decision

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: X.

X: Clinical notes X.

X: X denial letter, X denial letter, X preauth surgical form, X plan of care, evaluations, and notes from X PT, X PT script, X preauth request, X letter by X notes from X, MD, and DWC X.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient is a X-year-old X who sustained an industrial injury on X. The mechanism of injury was described as a X. X was diagnosed with a X. Records indicated that X was recommended for X treatment. X treatment had included X modification, X therapy. The X therapy chart notes documented X score X on X, with continued pain to grade X X remained X The X chart notes documented x-ray findings of X with no change in X healing. The X surgery initial report cited moderate X pain, X. Current medications included X. X exam documented range of motion to include X, X, X, X, X, X, X, X,X. All other X ranges of motion were symmetrical. X function was within normal limits. There was tenderness over the X and X. There was no X instability. The diagnosis included X, X, and X. It was noted that since the X, X faced X at X discretion, but that would require X. Currently, X might consider rehabilitating X current malunion, judging X satisfaction with time, and making a later decision whether X wanted X. X opted for correction now. Authorization was requested for X with X harvest, X. The X utilization review determination indicated that the request for X with X, X was non-certified. The rationale stated that there was no updated imaging report to objectively validate delayed healing as surgery was not recommended in the absence of displacement or delayed healing, and subjective and objective findings were limited to support the need for this surgery request. Exceptional factors could not be clearly identified to warrant this non-recommended procedure. The X report cited current symptoms of constant pain spanning from far X at the level of the trauma, exacerbated by any movement or application of added force. X reported extreme stiffness, worst in X, but most painful attempted motion was XX where X felt extreme pain at the X, and X could not XX at all. X stated that X was completely unable to do X job and would not be able to do so unless these limitations could be addressed. X reported that there was a X, and

X was unable to perform during the code, which placed the X directly tied to X performance. X exam documented range of motion to include X, X, X, X, X, X, X, X, X,X. All other X. X and X function was intact. There was tenderness to palpation over the X. There was no X instability. The diagnosis included extra-X, X, and X. The patient had a X of the X. At now greater than three months from original injury, X subjective symptoms and objective motion deficits had a direct relationship to X. X had clearly stated that X could not perform X current job in X current status. It was noted that the reviewer denied the surgical request based on the Official Disability Guidelines for X, which is not applicable in this case of X. The denial indicated that surgery was not indicated in the absence of displacement, and X had a major displacement clearly evident in X file. Additionally, the article referenced was relative to X of the X, and there was not a single reference in the denial not that addressed the actual topic of X. The standard treatment for high-grade, X limiting X was correction should be offered to the patient to optimize motion and function and minimize symptoms. There was abundant literature relating the extent of X to clinical symptoms and restriction of motion. X high-grade malunion was clearly documented by X radiographs. The method of treatment was straight forward and standard and absolutely required X placed into the large void created by the X. The X utilization review determination indicated that the appeal request for X corrective X with X, X was non-certified. The rationale stated that there was still no updated imaging report to objectively validate delayed healing as per guidelines it was not recommended in the absence of displacement or delayed healing. The recent objective findings were still limited to support the need for this surgery request. There were no pertinent clinical or extenuating circumstances that would require deviation from the guidelines.

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

The Official Disability Guidelines provide recommendations for the surgical treatment of X. Criteria for surgery generally include: X; or, X and/or, X greater than 10 degrees; and/or, X surface greater than 2mm. Guidelines do not address the treatment of X or provide recommendations for corrective X.

PubMed was searched and applicable evidence based medical literature was found regarding the treatment of X. Mulders et al concluded that corrective X is an effective method of treating symptomatic X with good long-term functional results, measured with the X score, and improvement in radiographic parameters and pain scores. Additionally, no differences in functional outcomes were found between X. X concluded that repositioning X consistently restores joint alignment and achieves functional improvement either in cases of nascent simple malunion or complex X.

This patient presents with complaints of persistent X pain and extreme stiffness. Functional limitations are noted in activities of daily living and severely limit X

work ability. Clinical exam findings have documented significant loss of range of motion. The X surgeon has reported X findings of X with major displacement. X has reasonable and/or comprehensive conservative treatment, including X. Current evidence based medical literature would support surgical treatment of this patient's X, including corrective X and X for functional restoration. Therefore, this request for X, X 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, OUTCOMEFOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**