True Decisions Inc.

Notice of Independent Review Decision

Case Number: XX Date of Notice: 3/6/2019 10:18:48 AM CST

True Decisions Inc.
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IRO REVIEWER REPORT

Date: 3/6/2019 10:18:48 AM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX XX XX X 3 XX Tendon

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

REVIEW OUTCOME:

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

☐ Overturned Disagree

☐ Partially Overturned Agree in part/Disagree in part

☒ Upheld Agree

PATIENT CLINICAL HISTORY [SUMMARY]: XX. XX XX is a XX-year-old XX-XX-dominant XX who had a XX XX to XX XX XX on XX, when XX reported that XX XX XX got XX in a XX XX. XX sustained XX XX to the XX XX, XX, and XX XX XX segments with XX XX XX disruption of the XX XX and XX XX. XX. XX underwent repair of XX XX, XX and XX XX fractures via open reduction and XX pinning and repair of XX XX, XX and XX XX XX XX XX tendon injuries on XX by xX, XX. The pre- and postoperative diagnoses were XX XX, XX and XX XX XX XX XX tendon lacerations and XX XX, XX and XX XX XX XX fractures. XX. XX visited XX, XX on XX for a follow-up. XX complaint was that XX was pinned for XX months; therefore, XX tendons were stiff. XX was inquiring regarding XX for better XX XX XX motion of the XX XX, XX and XX XX. XX had

completed therapy and felt that XX was not improving for the prior XX months. XX continued to feel weakness in XX XX, frequently XX XX, and the XX was not good due to inability to flex the XX XX XX. On examination, XX had intact sensation in all areas except the XX side of the XX XX XX and radial side of the XX XX XX (although the XX XX had XX side injury per the operative note). XX felt XX's sign when the XX was tapped, with improving sensation since the prior visit. XX XX xX function was passively intact in the XX and XX XX, and almost none even passively in the XX XX. Actively, there was about 20 degrees flexion in XX and XX XX and minimal in the XX XX. XX XX assessed XX. XX was status post XX XX XX repair to XX, XX, and XX XX of the XX XX with persistent flexion deficit. XX. XX was to continue range-of-motion exercises. Options were given to do nothing versus XX versus fusing the XX XX XX in flexion. XX, XX evaluated XX. XX on XX for a follow-up. XX stated XX was doing well; however, XX had no change in function of XX XX. XX continued to have poor strength and decreased range of motion of XX XX XX joints. XX was no longer doing therapies. Examination of the XX XX demonstrated that XX. XX had no flexion at the XX XX joint of XX XX XX, XX XX, and XX XX. XX also had a decreased sensation of the XX border of XX XX XX and the radial border of XX XX XX. There was also slight XX of the XX XX on passive flexion. XX was otherwise neurovascularly intact to XX median, XX, and radial nerves, and had a palpable radial pulse. XX noted that XX. XX had not reached maximum medical improvement at the time. The plan was for XX to return on XX for a XX surgery to aid in the flexion of XX XX XX joints. X-rays of the XX XX dated XX revealed chronic healed posttraumatic changes of the XX, XX, and XX XX middle XX. Treatment to date included medications, XX, surgical intervention, XX, and XX therapy. Per a utilization review and a peer review dated XX, by XX, XX, the request for XX of the XX XX x3 XX tendon (XX x3) was noncertified. Rationale: "The patient does have loss of ROM of the XX, XX, and XX XX. However, there was no indication / documentation of strength was good in XX / extensor muscles of the XX. Furthermore, there is limited documentation of prior conservative care (OT or HEP) and indication the patient would be willing to commit to a rigorous course of postoperative XX therapy as recommended by the guidelines. I made multiple attempts to contact the surgeon to garner additional information or exceptional circumstances. This was unsuccessful. Therefore, based upon the provided documentation, the request is not currently supported." Per a reconsideration review and a peer review dated XX by XX, XX, the appeal request for XX of the XX XX x3 XX tendon (XX x3) was noncertified. Rationale: "During the peer discussion, it was stated the patient had XX their XX in a XX machine, with fractures that were fixed. There is passive motion of the DIP, but no active. The range of motion was discussed, with 0 active range of motion. The provider suspects XX, as there is tightening of the FTP when they contract. The patient has had therapy, it is stated. After this discussion, the patient has full passive motion of the DIP, but no active. There has been a previous repair, it is stated. No further clinical information was given to overturn the previous decision. Therefore, the request for XX XX XX x 3 XX Tendon remains not medically necessary."

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

The claimant had been followed for XX XX complaints following multiple fractures of the XX that required surgical stabilization. The claimant did attend XX therapy following surgery; however, only a few of the therapy reports were submitted for review. There were no current evaluations of the claimant available for review. The last evaluation was from XX of XX which did not include any range of motion measurements specifically. Strength measurements were not provided. It is also unclear if the claimant had reached a plateau with formal XX therapy. As such, it is this reviewer's opinion that medical necessity is not established and the prior denials are upheld.

Given the documentation available, the requested service(s) is considered not medically necessary and the decision is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE

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DECISION:

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☐ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

XX See also XX release surgery (XX).