MedHealth **R**eview, **I**nc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

DATE NOTICE SENT TO ALL PARTIES: 2/27/19

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of an XX XX XX device.

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. The reviewer has been practicing for greater than 10 years.

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 agrees with the previous adverse determination regarding the prospective medical necessity of an XX XX Flexionator device.

PATIENT CLINICAL HISTORY [SUMMARY]:
This patient is a XX-year-old XX who sustained an XX injury on XX. The mechanism of injury was not well documented in the available medical records. XX was diagnosed with XX XX XX and XX. XX underwent XX XX XX with XX XX of XX, multicompartmental XX, XX XX release, and manipulation under anesthesia on XX. The XX orthopedic report indicated that the patient was attending XX therapy but had not gotten XX XX yet. Range of motion findings were not documented. The XX orthopedic report indicated that the patient was in XX therapy XX times a week and still had some stiffness with walking. XX therapy documented that range of motion was improved, but still limited. A XX injection was performed to the XX XX. The treatment plan recommended practicing a normal gait, continued XX therapy, and sedentary work. The XX

orthopedic report indicated that the patient was attending XX therapy XX XX a week and was improving. XX was still adjusting to walking normally. XX therapy documented near full extension with 100 degrees of extension today, but 109 degrees in XX therapy which was an improvement. XX was to continue XX therapy. The XX orthopedic report indicated that the patient was attending XX therapy XX times a week and was improving and walking better. XX still had some weakness. XX XX exam documented near full extension, and 110 degrees of extension today, but 120 degrees in XX therapy which was an improvement from the last visit. Continued XX therapy was recommended. The XX vendor request indicated that the XX XX XX was being requested for XX-days from XX to XX. It was noted that a XX physician prescription was attached with recertification date of XX. The XX peer review report denied the request for flexionator for dates of service XX to XX as not medically necessary. The rationale stated that the patient appeared to have 110 degrees of flexion with the XX therapist reporting 120 degrees which did not support the continued need of a XX flexionator. The XX vendor appeal letter indicated that the patient had met the Official Disability Guidelines as XX had met XX weeks of unsuccessful XX therapy alone. The plan was to meet XX functional goals to return to work. The XX XX Flexionator was ordered by the orthopedic surgeon to help XX each XX range of motion goals. XX was still lacking functional range of motion per the XX therapy notes, showing range of motion was 110 degrees in forward and full forward flexion of 160-180 degrees. XX was not at a functional range of motion. Continued use of the XX device was ordered for XX-days. It was noted that the patient had completed more than XX weeks of XX therapy. XX had been compliant and timely with XX therapy but continued to not meet goals for activities of daily living. XX therapy alone was not working for the patient to meet XX range of motion. The XX XX XX was a high-intensive stretching device that was used in the patient's home to mimic XX therapy and sustain range of motion. The XX peer review report denied the appeal request for XX-day use of a XX flexionator for the XX XX. The rationale stated that the patient had 110 degrees of XX flexion and prior use of this device was approved on XX without a good result. The XX orthopedic report indicated that the patient was in XX therapy and improving. XX still had a little trouble with strength and stiffness. XX therapy documented improved range of motion, improving gait, and slightly decreased strength. The patient was to continue XX therapy and begin working on strengthening XX XX and core. Work status was documented as modified work with restrictions outlined.

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

The Official Disability Guidelines recommend XX XX/XX as an option in conjunction with continued XX therapy if XX weeks of XX therapy alone has been unsuccessful in adequately correcting range of motion limitations secondary to postoperative XX (excessive scar tissue within and around a joint) within XX months of major XX surgery. The goal would be to address specific range of motion limitations that cause functional limitations in return to work; ongoing

patient compliance with the device needs to be documented; and device rental would be preferred.

This enrollee presents status post XX XX XX with XX XX of adhesions, multicompartmental XX, lateral XX release, and manipulation under anesthesia on XX for a diagnosis of XX. Records indicate that XX has been prescribed a XX XX since at least XX. XX is continuing to attend XX therapy. Records document current XX range of motion with full flexion and apparent XX flexion to 110-120 degrees. XX is reported with improving range of motion and gait, and slightly decreased strength. Under consideration is a request for EMRI XX XX from XX to XX. Guideline criteria have not been met for continued flexionator use. A specific rationale is not presented by the orthopedic surgeon to support the medical necessity of additional flexionator use. Current range of motion appears to be within functional limits allowing for return to work modified duty. There is no discussion of patient compliance with the use of the XX. Additionally, the patient was nearly XX months post-operative at the time of this request. Therefore, this request for XX XX XX device is not 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)**