

C-IRO, Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW:

AUGUST 8, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Purchase of AFO solis ankle left, purchase of soft interface below knee SE, purchase of varus/valgus strap padded/LI, purchase of plastic mod low Ext. pad/line and purchase of low EXT orthosis per Bar/JNT

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

Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Denial Letters 7/13/07 and 7/24/07
Operative report, 05/10/99
EMG/NCS, 09/16/99
Office notes, Dr. 04/05/01 and 08/24/04
Office notes, Dr. 10/12/01, 06/07/02, 04/04/03 and 0/13/04
Office note, Dr. 07/19/02
Peer review, 06/08/04

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained a left knee injury when he slipped and fell. Complete peroneal nerve palsy with associated foot drop was noted following the injury.

He underwent anterior cruciate ligament reconstruction, posterolateral ligament repair, partial medial meniscectomy and neurolysis of the peroneal nerve on 05/10/99. Intra-operative findings included a proximal fibula fracture that entrapped the peroneal nerve. Electrodiagnostic studies performed on 09/16/99 indicated no response in the peroneal nerve and marked denervation in its distribution. In early 2004 he underwent a cable grafting procedure and continued the use of an ankle foot orthosis. A very mild Tinel's and a little bit of tibialis anterior function was noted on 08/24/04 and he continued to require bracing. In 2001 it was noted that he did not obtain any improvement in the nerve and a new custom ankle foot orthosis was prescribed. In 2002 he was also seen for left knee pain without instability or effusion. He treated with anti-inflammatories. On 07/19/02 the claimant was seen for possible split posterior tibial tendon transfer. Physical examination demonstrated a steppage gait with only the flexor hallucis brevis functioning normally and no sensation along the posterior tibial nerve distribution. Dr. felt the claimant would not appropriately benefit from surgical intervention and would be a fall risk without ongoing ankle foot orthosis. Adjustments in the current brace were requested as well as compressive stockings. Radiographs from 07/19/02 indicated the ankle and subtalar joints remained in good condition without deformity. Dr. indicated when a new brace was needed improvements could be made. In 2003 he was measured for an anterior cruciate ligament brace for knee pain and swelling. His examination noted good knee stability with medial joint line tenderness. In 2004 examination noted anterior compartment atrophy and continued use of a drop foot brace. No records past 05/13/04 were provided for review.

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

This male has been referred for AFO brace for drop foot. Records reflect that he had a peroneal palsy following a previous injury. Records reflect that he has used an AFO for years. Unfortunately, there are no records beyond notes from May 2004. It appears as though the brace that is recommended is actually more involved than the traditional AFO that this gentleman has used in the past.

As such, in the absence of documented clinical change and/or the indications for a brace beyond that which he has used in the past, the Reviewer cannot recommend this as being reasonable and medically necessary. This does not deny the fact that there are absolute medical indications for an AFO brace.

At issue is as to whether or not this is a change from his previous brace and as to whether or not the clinical information supports an alternative brace to those that have been provided in the past.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates; Ankle- does not specifically address AFO bracing for foot drop.

Pain Management and Rehabilitation, Second Edition, Braddom; Chapter 16, page 331.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates; Knee and Leg-Knee Braces

Recommended as indicated below. There are no high quality studies that support or refute the benefits of knee braces for patellar instability, ACL tear, or MCL instability, but

in some patients a knee brace can increase confidence, which may indirectly help with the healing process. In all cases, braces need to be used in conjunction with a rehabilitation program and are necessary only if the patient is going to be stressing the knee under load. ([Bengal, 1997](#)) ([Crossley, 2001](#)) ([D'hondt-Cochrane, 2002](#)) ([Miller, 1997](#)) ([Yeung-Cochrane, 2002](#)) ([Van Tiggelen, 2004](#)) There are no data in the published peer-reviewed literature that shows that custom-fabricated functional knee braces offer any benefit over prefabricated, off-the-shelf braces in terms of activities of daily living.

Criteria for the use of knee braces:

Prefabricated knee braces may be appropriate in patients with one of the following conditions:

1. Knee instability
2. Ligament insufficiency/deficiency
3. Reconstructed ligament
4. Articular defect repair
5. Avascular necrosis
6. Meniscal cartilage repair
7. Painful failed total knee arthroplasty
8. Painful high tibial osteotomy
9. Painful unicompartmental osteoarthritis
10. Tibial plateau fracture

Custom-fabricated knee braces may be appropriate for patients with the following conditions which may preclude the use of a prefabricated model:

1. Abnormal limb contour, such as:
 - a. Valgus [knock-kneed] limb
 - b. Varus [bow-legged] limb
 - c. Tibial varum
 - d. Disproportionate thigh and calf (e.g., large thigh and small calf)
 - e. Minimal muscle mass on which to suspend a brace
2. Skin changes, such as:
 - a. Excessive redundant soft skin
 - b. Thin skin with risk of breakdown (e.g., chronic steroid use)
3. Severe osteoarthritis (grade III or IV)
4. Maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain)
5. Severe instability as noted on physical examination of knee

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**
 - Pain Management and Rehabilitation, Second Edition, Braddom; Chapter 16, page 331
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**