



Specialty Independent Review Organization

Amended Notice of Independent Review Decision

DATE OF REVIEW: 9/29/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The items in dispute are the prospective medical necessity of L5679 – Socket Insert w/o lock mechanism, knee shrinker L8460, sleeve suspension L8460, and single ply sock L8480.

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 Physical Medicine and Rehabilitation with greater than 10 years of experience.

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 L5679 – Socket Insert w/o lock mechanism and L8480 (single ply sock).

However, the reviewer agrees with the previous determination regarding the L8460 (sleeve suspension) and L8460 (knee shrinker).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

MD

These records consist of the following:

Records from the Doctor/Facility: MD 7/13/07, 2/22/07, 8/4/06 "Today he received a socket insert without lock, neoprene sleeve suspension," 9/17/04, 12/31/03, 3/30/01 and 2/6/01; MD 9/16/2000 Operative note indicating repair of wound, 9/10/2000 documentation of AKA.

Records from Carrier: 9/7/07 filing for dispute resolution; 7/27/06 LVN-authorization of socket insert without lock (L56791), neoprene sleeve suspension L5695; MD 7/13/06 prescription for prosthetic supplies/socks; Hanger orthotics 7/24/06, 8/4/06, 11/10/06, 12/7/06, 2/8/07, 2/15/07, 3/22/07, 8/9/07 "patient in with deteriorated cross comfort liner, deteriorated TES belt, and in need of single ply fitting socks. Will seek authorization,"; 8/30/07 notification of non-authorization (respectively L5679, L8460, L8460 and L8480) by MD 8/21/07 notification of non-authorization (respectively L5679, L8460, L8460 and L8480) by MD.

A copy of the ODG guidelines was not received from the Carrier or URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured during a back hoe accident at work. He underwent left, above the knee amputation on 9/6/2000.

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

The reviewer authorizes the purchase of the soft liner as made reference to by the prosthetist on 8/9/07 otherwise know as a gel type socket unit insert liner.

According to the ODG, the indications for socket insert w/o lock mechanism include the following: Prostheses are "Recommended as indicated below. A prosthesis is a fabricated substitute for a missing body part. Lower limb prostheses may include a number of components, such as prosthetic feet, ankles, knees, endoskeletal knee-shin systems, socket insertions and suspensions, lower limb-hip prostheses, limb-ankle prostheses, etc. See also Microprocessor-controlled knee prostheses.

Criteria for the use of prostheses:

A lower limb prosthesis may be considered medically necessary when:

1. The patient will reach or maintain a defined functional state within a reasonable period of time;
2. The patient is motivated to ambulate; and
3. The prosthesis is furnished incident to a physician's services or on a physician's order.

Prosthetic knees are considered for medical necessity based upon functional classification, as follows:

- a) A fluid or pneumatic knee may be considered medically necessary for patients demonstrating a functional Level 3 (has the ability or potential for ambulation with variable cadence) or above.
- b) Other knee systems may be considered medically necessary for patients demonstrating a functional Level 1 (has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence) or above. (BlueCross BlueShield, 2004)”

There is a dispute specifically on the request for the gel type socket insert liner also labeled or coded as socket insert w/o lock mechanism (L5679). The hand written documentation by the prosthetist from Hanger on 8/9/07 indicates deterioration of the insert liner (L5679) and sock (L8480). These items regularly require replacement due to wear and tear.

LVN documents authorization of socket insert without lock (L5679) on 7/27/06. Documentation on 8/4/06 by Dr. indicates that L5679 had been received.

Documentation is necessary to support renewal of this medical equipment. The peer reviewers have documented inability to communicate with the treating doctor of record in attempts to verify necessity.

No recent documentation was provided from the treating doctor to support the authorization of the socket insert w/o lock mechanism (L5679). However the prosthetist, documents that this item is deteriorated. Medicare will typically authorize replacement parts as needed or every 6 months. The documentation provided states that the equipment is more than one year old. There is no documentation that a new device has been received since 8/4/06.

Regarding the L8460 (times 2) and L8480, the reviewer indicates that the documentation provided by the parties does not document the medical necessity for the requested knee shrinker and sleeve suspension.

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)