

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 07/24/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

HCPCS coded L1832 hinged knee brace

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the HCPCS coded L1832 hinged knee brace is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Notice to URA of assignment of IRO – 07/09/08
- Information for requesting review by an IRO – 07/09/08

- Denial of Preauthorization or Concurrent review request from – 05/27/08, 06/05/08
- Request for preauthorization from – 05/20/08, 07/08/08
- Prescription for hinged knee brace – 05/20/08
- Subsequent – 04/04/08, 04/25/08, 05/13/08, 06/17/08
- Operative Report by – 05/14/08
- Patient registration form for – 03/20/08
- Request for review by an IRO . – 07/08/08
- Physician Determination – Appeal – 05/30/08
- Physician Determination – Initial – 05/21/08
- Appeal from . – 05/28/08
- Report of MRI of the Left knee – 03/31/08
- Notice of Disputed Issue(s) And Refusal to Pay Benefits – 05/29/08
- Initial orthopaedic consultation worker's compensation by – 03/20/08
- Report of x-rays of the left knee – 05/14/08
- Emergency Room Report – 03/16/08

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx resulting in a tear of his left anterior cruciate ligament (ACL). This ligament was a reconstructed ligament as the patient had undergone ACL reconstruction in 2001. On 05/14/08 a reconstruction of the ACL ligament was performed and a hinged knee brace was prescribed to protect the reconstructed ligament from injury during healing.

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

The ODG provides what might be considered inconsistent statements with regard to the use of knee braces after ACL reconstruction surgery. In one portion of the passage related to the use of braces after ACL reconstruction surgery, the ODG states, “...There is no data in the published peer-reviewed literature that shows that custom-fabricated functional knee braces offer any benefit over prefabricated, off-the-self braces in terms of activities of daily living. (BlueCross BlueShield, 2004) The use of bracing after anterior cruciate ligament (ACL) reconstruction cannot be rationalized by evidence of improved outcome including measurement of pain, range of motion, graft stability, or protection from injury...” Toward the end of the same passage under “Criteria for use of knee braces” the ODG includes “...Prefabricated knee braces may be appropriate with one of the following conditions...#3 Reconstructed ligament...” Therefore, it is determined that a prefabricated knee brace is appropriate to treat this patient's condition. It is common practice to protect a reconstructed ACL ligament with a “derotation knee brace”. While there is no indication for a custom fabricated brace; a prefabricated brace will provide the necessary protection.

**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)