Advanced Medical Reviews

URAC ACCREDITED EXTERNAL REVIEW

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 3/26/2008
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right leg prosthesis

QUALIFICATIONS OF THE REVIEWER:
This reviewer graduated from West Virginia University School of Medicine and completed training in Orthopaedics at University of South Carolina. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Orthopaedics since 7/11/1996.

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

X Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

Right leg prosthesis Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Clinical note dated unknown
2. Request for a review dated 3/7/2008
3. Request for a review dated 2/27/2008
4. C linical note by MD dated 1/10/2008
5. Clinical note by MD dated 2/8/2008
6. Case assignment dated 3/10/2008
7. Clinical note dated 1/15/2008
8. Letter of medical necessity dated 1/15/2008
9. Certificate of medical necessity dated 12/11/2007
10. Assessment validation evaluation test dated unknown
11. Clinical note dated 5/7/1999
12. code update dated 11/6/2001
13. Practice recommendations dated unknown
14. Evaluation of function dated unknown
15. Functional evaluation dated unknown
16. Quality of life dated unknown
17. Clinical note dated 1/7/2008
18. Clinical note dated 12/17/2007
19. Microprocessor knee evaluation dated 11/9/2007
20. Assessment validation evaluation test dated unknown
21. Clinical note dated 12/17/2007
22. Clinical note dated 12/18/2007
23. Clinical note dated 12/18/2007
24. Request for a review dated 2/27/2008

25. Clinical note by CO dated 3/3/2008
26. Clinical note dated 1/15/2008
27. Official Disability Guidelines (ODG)

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a transfemoral amputee secondary to trauma with a date of injury x/xx/xxxx. The injured employee was noted to utilize a preparatory prosthesis that was over 3 months old and was in need of replacement. The patient had complaints of a rash he got with the socket, as it was hot and made him sweat. He required a microprocessor-controlled prosthetic knee joint Otto Block C-Leg with ischial containment socket and compatible foot to meet his day to day needs.

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

This claimant is a male who was injured. A new right leg prosthesis has been requested including a microprocessor controlled prosthetic knee, Otto Bock C Leg with ischial containment socket, and a compatible foot. Prior peer reviews indicated that the device was non-certified. A more recent letter from Hanger Prosthetics of 03/03/2008 provides an appeal.

The ODG Guidelines were also available for review. Fluid or pneumatic knees are considered medically necessary in individuals demonstrating a functional level three with the ability or potential to ambulate with a variable cadence. Microprocessor controlled knee prostheses are considered to be under study. The data are felt to be inadequate to define the improvement in health outcomes related to the increased sophistication of the prostheses. The data are not felt to be sufficient to determine who might benefit from them. The microprocessor controlled prosthetic knee joint requested does not meet the ODG criteria. Therefore, the previous denial is upheld.

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
X 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)