

Independent Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: September 15, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Uploading Knee Brace

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

Board Certified in Physical Medicine and Rehabilitation

Subspecialty Board Certified in Pain Management

Residency Training PMR and ORTHOPAEDIC SURGERY

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

OD Guidelines

Denial Letters 8/5/08 and 8/15/08

Medical Services 8/28/08

Summary No date

Records from Dr. 4/17/08 and 7/23

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical information was actually limited to the 8/28/08 review from the Medical Clinic. It reported the original injury occurred in xxxx and that she had a tear of the posterior horn of the medial meniscus. Regional sympathetic dystrophy had been

excluded and the pain felt to be a referred radicular tingling pain in the calf and buttock. She had prior knee MRIs and surgery. None of this was provided. tear of the medial meniscus. The only other note from Dr. was dated 7/23/08 and cited that she had significant knee pain. He said she had known severe internal derangement of the knee with crepitation.

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

After a careful review of all medical records, the Reviewer's medical assessment is that the requested knee brace is not medically necessary. The local tenderness could reflect medial collateral burstitis. The crepitation could be from the patellofemoral joint. The note stated she has internal derangement of the knee. The Reviewer could not determine if the problem is in the medial compartment which would justify the brace, or generalize, which would not. The material provided states she had a velcro knee brace not fitting and that she has internal derangement of her knee. The material did not describe any isolated compartment problem for an unloading type brace.

Criteria for the use of knee braces: (ODG)

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 unicompartamental 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 (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)