



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

DATE OF REVIEW: 7-1-09 (AMENDED 7-6-09)

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Postoperative knee brace and 14 day rental of cryo therapy unit unit 6-1-09

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

American Board of Orthopaedic Surgery-Board Certified

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 3-23-09 X-rays of the left knee dated.
- 3-23-09 MRI of the left knee.
- 4-8-09 MD., office visit.
- 4-23-09 MD., performed a Utilization Review.
- 6-1-09 performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

X-rays of the left knee dated 3-23-09 showed probable left knee effusion.

MRI of the left knee dated 3-23-09 showed tear of the medial meniscus, tear of the lateral meniscus, partial tear of the anterior cruciate.

On xx-xx-xx, MD., notes the claimant is a male who suffered a worker's compensation injury while working. The claimant reported he stepped down from a man lift, stepping into a hole covered with snow, causing him to twist his left knee. An MRI was done up north and recommended surgery. On exam, the claimant has no malalignment, asymmetry, crepitation, defects or effusion. There is generalized swelling. Stability assessment revealed no luxation or subluxation. Strength was 5/5; the claimant had normal tone and no atrophy. Range of motion was 115 degrees of flexion and 5 degrees of extension. The MRI showed possible ACL tear. The evaluator recommended arthroscopy to remove the torn meniscal tissue/damaged tissue. The evaluator noted that there is an 85% chance that pain secondary to the torn meniscus will be relieved.

DME prescription form for hinged range of motion brace and pneumatic compression using x 14 days provided on xx-xx-xx.

On 4-23-09, MD., performed a Utilization review. It was his opinion that anterior cruciate ligament reconstruction is not medically necessary and indicated. Therefore, the requests for 14-day rental of a cryo therapy unit and postop knee brace would not be medically necessary.

On 6-1-09, performed a Utilization Review. It was his opinion that since the requested procedure is not indicated this obviates the need for postoperative durable medical equipment.

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

GIVEN THAT THE REQUESTED PROCEDURE WAS NOT INDICATED, THE REQUESTS FOR A 14-DAY RENTAL OF A CRYO THERAPY UNIT AND POSTOP KNEE BRACE WOULD NOT BE DEEMED MEDICALLY NECESSARY. ODG-TWC GUIDELINES STATE THAT CRYO THERAPY UNIT IS NOT RECOMMENDED FOR NONSURGICAL TREATMENT.

ODG-TWC, last update 6-25-09 Occupational Disorders of the Knee – 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. (BlueCross BlueShield, 2004) The use of bracing after anterior cruciate ligament (ACL) reconstruction cannot be rationalized by evidence of improved outcome including measurements of pain, range of motion, graft stability, or protection from injury. (Wright, 2007) Among patients with knee OA and mild or moderate valgus or varus instability, a knee brace can reduce pain, improve stability, and reduce the risk of falling. (Zhang, 2008) Patellar taping, and possibly patellar bracing, relieves chronic knee pain, according to a recent meta-analysis. Patellar taping may be preferred over bracing due to the fact that there is much more evidence for taping than bracing, and also because taping produces better clinical results in terms of reductions in pain than patellar bracing, plus patients are more active in their rehabilitation with taping than with bracing. (Warden, 2008)

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

ODG-TWC, last update 6-25-09 Occupational Disorders of the Knee – cryotherapy unit: Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. (Hubbard, 2004) (Morsi, 2002) (Barber, 2000) The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting. (BlueCross BlueShield, 2005) This meta-analysis showed that cryotherapy has a statistically significant benefit in postoperative pain control, while no improvement in postoperative range of motion or drainage was found. As the cryotherapy apparatus is fairly inexpensive, easy to use, has a high level of patient satisfaction, and is rarely associated with adverse events, we believe that cryotherapy is justified in the postoperative management of knee surgery. (Raynor, 2005) There is limited information to support active vs passive cryo units. Aetna considers passive hot and cold therapy medically necessary. Mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. (Aetna, 2006).

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)**