

# P&S Network, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 11/10/2009

**IRO CASE #:**

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

This case was reviewed by a Pain Management (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

DME Lt Below Knee Prosthesis L5301, L5620, L5637, L5629, L5645, L5940, L5910, L5986

### **REVIEW OUTCOME**

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

Overtuned (Disagree)

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 09-27-07 Operative report- amputation PIP left foot from Dr.
- o 10-01-07 Medical report, eval at hospital from Dr.
- o 10-02-07 Laboratory reports through 12-23-09
- o 10-03-07 Medical report from Dr.
- o 10-03-07 Right knee and lumbar radiographs read by Dr.
- o 10-03-07 Foot and toe radiographs read by Dr.
- o 10-04-07 Chest film read by Dr.
- o 10-04-07 PICC placement imaging report from Dr.
- o 10-07-07 Discharge Notes following below knee amputation from Dr.
- o 02-07-08 Follow up report from Dr.
- o 03-27-08 New Patient Evaluation from Dr.
- o 05-27-08 Medical report from Dr.
- o 07-30-08 Medical report from Dr.
- o 12-08-08 Medical report from Dr.
- o 03-03-09 Medical report from Dr.
- o 06-01-09 Medical report from Dr.
- o 06-01-09 Prosthesis recheck report from Orthotics
- o 09-30-09 Fax request for new prosthesis from Orthotics & Prosthetics
- o 09-30-09 Prosthetic Prescription from Dr.

- o 10-01-09 Patient Evaluation Checklist from Dr.
- o 10-05-09 Initial non-determination letter
- o 10-05-09 Request for reconsideration, fax, from Dr.
- o 10-19-09 Notification of Reconsideration Determination
- o 10-20-09 Request for IRO from the provider
- o 10-26-09 Notice of Assignment of IRO from TDI

**PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records and prior reviews the patient is a male who sustained an industrial injury to the foot on xx/xx/xx when an 800 pound piece of equipment fell on his left foot. He progressed slowly and on

September 27, 2007 underwent amputation of the left foot PIP joint of the second toe, distal half of the distal phalanx of the hallux. He made slow progress again and was transferred to the current provider on October 1, 2007. On admission his left foot and left stump of the left great toe and second digit were gangrenous with a great deal of eschar and purulent drainage underneath the skin and an infectious disease consultation was ordered. He is a heavy drinker and smokes. His history is positive for hepatitis C (or B).

Initial urine and blood laboratory studies indicated normal results on October 2, 2007. Sodium was slightly low on October 9, 2007. Additional reports were normal through October 11, 2007. HCT was mildly low on October 12, 2007. Stool study was negative for occult blood on October 14, 2007. Potassium was slightly low on October 15, 2007. Red blood cells were low on October 15, 19, 24, 27 2007 and on December 22 and 23, 2007.

Radiographs of the foot taken on October 3, 2007 revealed extensive post-traumatic changes and post-operative changes. Erosive changes were suggested at the first distal phalanx and the second proximal phalanx. Vigilance for osteomyelitis was recommended. Right knee radiographs revealed degenerative changes involving the femoral patellar joint. Lumbar x-rays noted L5 transitional segment, facet arthropathy at L5-S1 and no bony abnormalities. Chest film noted a right peripherally inserted central catheter (PICC line) in place with interval improved aeration of the right upper lobe when compared to the previous study of 09/01/06.

The medical report of October 3, 2007 indicates the patient is status post ORIF of the left foot. Additional surgery was performed to remove skin. He was transferred and per an infectious disease specialist, debridement and antibiotics are not sufficient treatment. He then underwent a left below-the-knee amputation (BKA). He had an episode of hypertension and extreme pain. He was provided IV morphine. He will be transferred back for wound management. PT and ultimately, prosthesis fitting.

Progress notes of February 7, 2008 indicate the patient had a long hospital stay and went home to return with an infected BKA stump. He developed stump infection and gangrene and underwent a revision BKA in December 2007. The BKA stump is now well healed. He continues to smoke and has hypertension.

The patient returned to his current provider on March 27, 2008. The patient history is (now) said to be positive for hepatitis B. He is using Lortab, Lyrica and Cymbalta. He is 5'9" and 178 pounds. He has a prosthetic leg and is able to ambulate with the prosthetic leg and crutches. Norvasc is prescribed for his hypertension.

The patient is reevaluated by his primary provider every few months and by his orthopedic provider every six months. On June 2, 2009 the patient is using Lortab, Neurontin, lisinipril, Tofranil for phantom pain and Ambien. On June 1, 2009 the orthopedic provider noted his old prosthesis doesn't fit well and the patient complains of pressure on the boney areas. His stump is visibly smaller and boney areas such as the fibula head are noticeably more prominent. Previous adjustments were made on the last visit. Strongly suggest patient needs new prosthesis.

A new prosthesis was requested on September 30, 2009. The prescription form notes functional level of K3: Able to ambulate skillfully and with variable cadence, transversing most environmental barriers and uneven surfaces. K3 is checked.

The patient's device was checked by the prosthetic provider October 1, 2009. Fit, function and overall condition are assessed as poor. The device is under xxxx years of age. Handwritten note to state, 10 ply fit, liner is worn out = poor function.

Request for a new below the knee prosthesis was considered in review on October 5, 2009 and recommended for non-certification. Four pages of administrative and medical report were submitted. The mechanism of injury and medications were unknown to the reviewer. A new prosthesis was requested as the current prosthesis no longer fits and cannot be adjusted. ODG criteria were cited. The prescription reads, able to ambulate skillfully and with variable cadence, transversing most environmental barriers and uneven surfaces. The provider would need to submit additional information to clarify a medical necessity for a new prosthesis.

A fax from the provider dated October 5, 2009 states, requesting reconsideration. Please let me know if you need any further information.

Request for reconsideration was considered in review on October 19, 2009 with recommendation for non-certification. A peer discussion was attempted but not realized. 10 pages of clinical notes and administrative information were available for review. The reviewer states the patient's current subjective complaints and objective physical assessment of the knee amputation was not provided for review. Medical records failed to indicate that the patient is able to ambulate skillfully and with variable cadence, transversing most environmental barriers and uneven surfaces. There was no note of the length of use of the current prosthesis and how long the patient has been noting complaints. Further clinical information and insight may establish the medical necessity of this request.

An IRO was requested.

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

Per ODG, a prosthesis is a fabricated substitute for a missing body part and is supported with the criteria described below. According to the provider's prescription form, the functional level of the patient is K3: Able to ambulate skillfully and with variable cadence, transversing most environmental barriers and uneven surfaces. This is a check-the-box form description. Clinically, the patient's device is described as, fit, function and overall condition are poor. 10 ply fit liner is worn out resulting in poor function. The device is under xxxx of age. Four months prior, the provider noted in bi-annual reevaluation, his old prosthesis doesn't fit well and the patient complains of pressure on the boney areas. His stump is visibly smaller and boney areas such as the fibula head are noticeably more prominent. Previous adjustments were made on the last visit. Strongly suggest patient needs new prosthesis. The device is worn, doesn't fit well and is not functioning well and is resulting in increased symptoms to the patient. Per the patient's history, he smokes, has hypertension and is positive for hepatitis C (or B) and is thus at higher risk for infection. It would be reasonable to replace the device to provide mobility, as well as help prevent tissue breakdown.

Therefore, my recommendation is to disagree with the prior non-certification for DME Lt Below Knee Prosthesis L5301, L5620, L5637, L5629, L5645, L5940, L5910, L5986.

The IRO's decision is consistent with the following guidelines:

**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

The Official Disability Guidelines - Knee and Leg Chapter (10-12-2009) Prostheses:

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)