



## Medwork Independent Review

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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)*

**12/06/2010**

**DATE OF REVIEW: 12/06/2010**

**IRO CASE #:**

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

Protonics knee brace

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

Texas State Licensed MD Board Certified Orthopedic Surgeon

**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**

1. Texas Dept of Insurance Assignment to Medwork 11/17/2010
2. Notice of assignment to URA 11/17/2010
3. Confirmation of Receipt of a Request for a Review by an IRO
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 10/28/2010
6. Letter 11/22/2010, 10/19/2010, 10/01/2010, pre-auth 07/20/2010, letter of med nec 07/19/2010, eval 07/19/2010, OP report 07/08/2010, OT order, medical note 07/07/2010, 06/09/2010, 05/17/2010, 05/01/2010, 04/01/2010, 03/10/2010, 03/10/2010, 02/26/2010, 02/16/2010, 02/05/2010, MRI 02/03/2010, TDI forms 02/2010 – 05/2010
7. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**

The claimant is a male who sustained an occupational slip and fall left knee injury dated xx/xx/xx. He failed conservative treatment. He underwent a second-opinion orthopedic evaluation on June 9, 2010. The claimant complained of continuing left knee pain and locking of the left knee. He underwent a repeat left knee MRI scan and subsequent arthroscopic left knee surgery dated July 8, 2010. The surgical procedure included arthroscopic examination of the left



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knee, resection of the anterior cruciate ligament cyst, chondroplasty of the patella and medial tibial plateau micro-chondral fractures, and resection of the superomedial plica. He underwent postoperative physical therapy treatment had been prescribed the Protonics knee brace. The postoperative physical therapy treatment records indicate functional left knee ranges of motion and left quadriceps muscle atrophy/weakness.

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

The Official Disability Guidelines are silent with regard to this type of knee orthosis. The Medical Coverage Policy No. 0362 concerning knee braces is utilized. This evidence-based reference states that the Protonics knee brace is considered investigational/experimental, as there is insufficient scientific medical literature to support the requested knee brace; therefore, the insurer's decision to deny 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 KNOWLEDGBASE
- 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)

1. Cigna Medical Coverage Policy No. 0362