



COMPARTNERS



ACCREDITED
INDEPENDENT REVIEW
ORGANIZATION

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 3/8/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for durable medical equipment (DME): Playmaker brace L1832.

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

Texas licensed orthopedic surgeon.

REVIEW OUTCOME:

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> 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.

The previously denied request for DME: Playmaker brace L1832.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice of Case Assignment dated 2/16/10.
- IRO Request dated 2/12/10.
- Denial Letter dated 1/26/10.
- Treatment/Services Request dated 1/26/10, 1/4/10.
- Follow-Up Visit dated 2/1/10, 12/21/09.
- Note from Physician dated 12/21/09.
- Operative Report dated 11/30/09.
- Texas WC Work Status Report dated 2/1/10.
- ODG for Knee Brace (unspecified date).

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury: x/x/xx

Mechanism of Injury: Not provided.

Diagnosis: Anterior cruciate ligament (ACL) tear, medial and lateral meniscal tears and traumatic chondral injury.

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

This male sustained an injury to his right knee on x/x/xx. The mechanism of injury was not provided. The diagnoses were ACL tear, medial and lateral meniscal tears and traumatic chondral injury of the lateral compartment. On 11/30/09, the claimant underwent a right knee ACL reconstruction utilizing autologous hamstring tendons, partial medial and lateral meniscectomy, and chondroplasty utilizing abrasion and microfracture technique, lateral tibial plateau and patellofemoral articulation. Post-operative evaluations revealed no evidence of complication and the claimant appeared to be making satisfactory progress. On 02/01/10, the claimant was able to fully extend his right knee and flex to 115 degrees. Anterior and posterior drawer testing were negative. There was no clinical report of knee joint instability. The treating physician requested a Playmaker knee brace.

The ODG note that prefabricated knee braces may be appropriate in patients who have had a reconstructed ligament, such as this claimant. However, this claimant had been prescribed a custom Playmaker brace. The ODG also gives indications for the use of custom fabricated knee braces that were inconsistent with the claimant's postoperative status. There was no documentation that he had an abnormal limb contour, skin changes, severe osteoarthritis, severe instability or significant pain off loading. The previous adverse determination 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 AND 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. Official Disability Guidelines (ODG), Treatment Index, 8th Edition (web), 2010, Knee – Braces.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).