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Notice of Independent Review Decision

DATE OF REVIEW: May 12, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

L 1845 DME Purchase: Right knee brace

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

Certified, American Board of Orthopaedic Surgery

REVIEW OUTCOME

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI

- Utilization reviews (02/23/10, 03/18/10)

ODG have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was doing heavy lifting when she experienced swelling of the right knee on xxxxxxxx.

xxxxx: In xxxxx, the patient was evaluated at xxxxx by, M.D., for complaints of right knee pain, swelling and inability to weight bear. Examination revealed tenderness over the medial and lateral joint lines an effusion in the knee. X-rays revealed partial loss of the medial femorotibial joint space with mild-to-moderate spurring of the medial femoral condyle. Dr. diagnosed acute sprain of the right knee, prescribed Motrin and Lortab and provided a knee immobilizer and knee crutches and placed her off work for three days.

Magnetic resonance imaging (MRI) of the right knee revealed: (1) Three-compartment osteoarthritis greatest at the medial compartment where there was grade IV chondromalacia and prominent myxoid changes at the mid body of the medial meniscus and some probable mild free margin fraying. (2) Small knee joint effusion and tiny subcentimeter potential Baker's cyst. (3) Small loose bodies at the anterior joint line at the intercondylar sulcus.

The patient was evaluated again at the Boerne Urgent Care, was prescribed naproxen and was released to work as tolerated. She was placed at clinical maximum medical improvement (MMI) as of September 18, 2009, without any permanent impairment as a result of the compensable injury. She was told the injury would result in no limitations and could be limited only by her pre-existing arthritis/degeneration.

M.D., noted diffuse swelling in the right knee, inability to fully flex or extend and positive effusion sign. He administered a joint injection along with a trigger point injection (TPI), prescribed Mobic and referred her for orthopedic consultation as well as physical medicine and rehab.

In October, a functional capacity evaluation (FCE) placed the patient in a light physical demand level (PDL). The evaluator recommended orthopedic evaluation prior to attempting a return to work. Through November, the patient attended five sessions of PT consisting of ultrasound, therapeutic exercises, neuromuscular re-education and joint mobilization. A neuromuscular electrical stimulator (NMES) was prescribed.

2010: M.D., noted worsening pain in the right knee for the past six months associated with stiffness and swelling. Examination revealed tenderness over the medial joint line, positive crepitus at extension, minimal tenderness along the medial and lateral patellar facets and mildly positive medial McMurray's. Dr. diagnosed internal derangement of the right knee and primarily medial compartment chondral derangement and opined that although the patient's cartilage derangement was mostly likely pre-existing it was because of her work activities that she had an acute exacerbation of her right knee pain that had not previously been documented or felt by the patient. Hence, the patient's right knee pain was compensable. Dr. further opined initial treatment should consist of activity modification, anti-inflammatory medications, PT consisting of quadriceps strengthening and 10 corticosteroid as well as visco supplementation injections. Ultimately, it was likely that the patient would require medial compartment versus bicompartamental arthroplasty and total knee arthroplasty. An OA assist unloader brace was prescribed and approval for the right knee steroid injection and x-rays were submitted.

On February 23, 2010, M.D., denied the request for a right knee brace based on the following rationale: *"The medical documentation indicates that the brace is a medial unloader brace. This brace would be treatment for osteoarthritis, which is a disease of life. There is inadequate reason for treatment of osteoarthritis under the xxxxx, injury claim."*

M.D., an orthopedic surgeon, performed a peer review and rendered the following opinions: (1) The patient's current condition and the findings of the MRI

were not a result of the occupational event. The mechanism of injury could not have lead to the multiple MRI findings, which were age related, pre-existing and noncompensable. A causal relationship between the reported injury and the patient's current complaints was not established. It was reasonable to conclude that this patient would experience these complaints and conditions even in the absence of the work injury. In reasonable medical probability, the patient sustained a minor, grade I right knee sprain and strain. (2) A complete recovery for the compensable diagnosis would be expected within three to four weeks, which in this case was delayed due to the pre-existing osteoarthritis. (3) FCE, work hardening program/work conditioning program (WHP/WCP), pain management program and further diagnostic testings were not indicated. The ideal treatment would include ice application for the first 24 hours, a 40-50 pound weight loss, a home program of knee stabilization exercises, an Ace support or knee brace, over-the-counter medications, minimal PT one to two a week for three weeks, a 1500 calorie no-salt diet and gradual resumption of activities including work in a sedentary position. After four to six weeks, the patient should be referred to a private healthcare provider or University Hospital for further conservative management of the underlying age-related degenerative osteoarthritis.

In March, an attorney for the claimant, stated that he did not feel it was an appropriate medical review of the requested DME as the reviewer had responded indicating there was inadequate reason for treatment of osteoarthritis under the xx/xx/xxxx injury claim. The prescribing doctor and the DME provider company submitted a diagnosis of internal derangement and not osteoarthritis.

In March, Dr. noted right knee minimal swelling and tenderness at the medial superior quadrant, recommended a knee joint brace and an orthopedic referral.

On March 18, 2010, M.D., denied the appeal for the medial unloader knee brace. Rationale: *"The knee MRI revealed no acute, traumatic or occupational pathology but did reveal tricompartmental osteoarthritis. A knee brace for a disease of life is not medically necessary under the occupational injury claim."*

On April 9, 2010, Dr. issued a letter of medical necessity for the neuromuscular stimulator (NMES) unit.

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

The assessment of the clinical scenario and interpretation of ODG criteria pursuant to the medial unloader brace appears to have been accurately derived by the reviewing physicians. There is insufficient objective clinical or imaging evidence presented by the requestor to substantiate a diagnosis of acute internal derangement, or a temporary exacerbation of pre-existing DJD, or a permanent aggravation of pre-existing DJD that would require treatment with a medial unloader brace as part of any work-compensable MOI.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT
GUIDELINES**