

SENT VIA EMAIL OR FAX ON
May/03/2010

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/30/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

DME Knee Orthosis Double Upright

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Denial Letters 3/30/10 and 3/9/10
xxxxx 3/4/10
Dr. 10/16/09 thru 3/22/10
Radiology Report 2/20/10
xxxxxx 5/27/09 thru 4/12/10

PATIENT CLINICAL HISTORY SUMMARY

This is a injured xx/xx/xx. The records provided describe degeneration of the knee and lumbar radiculopathy. Most of the records stated antalgic gait. There was no description of knee motion, or instability. The MRI from 2/20/10 described an old posterior horn of the medial meniscus tear and chronic ACL sprain. There is a checklist letter of necessity for the brace stating it would reduce pain, instability and improve the range of motion (3/4/10). A 3/22/10 letter noted that the brace was needed because of a cardiac condition that precluded elective knee surgery. Again, it was written for knee stabilization and pain control. Dr. wrote there was instability, but did not describe the extent.

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

There is a paucity of the description of the knee problem other than antalgic gait and the MRI. The ODG notes no studies supporting or refuting the brace for ACL tears. It has value for medial and lateral instability in arthritic knees, but that was not described in the records. It

permits the brace if there is a concomitant therapy program and if the knee is to be under load. The ODG permits the use of prefabricated orthoses with instability and ligamentous instability. Dr. never described this in the notes, but touched upon them in the more detailed letter of medical necessity. In consideration of the multiple factors, the medical necessity and benefit are not clear, but are reasonably possible. Therefore, the request for the orthosis is medically necessary.

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

ACOEM-AMERICA 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)