

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 11/16/2010
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right below knee preparatory prosthesis

QUALIFICATIONS OF THE REVIEWER:

Physical Med & Rehab, Pain Management

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)

Right below knee preparatory prosthesis Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Fax page dated 11/3/2010
2. Letter by DO, dated 10/29/2010
3. Request for a review by author unknown, dated 10/22/2010
4. Progress note by DO, dated 10/21/2010
5. Notification of adverse determination by DO, dated 10/5/2010
6. Letter by DO, dated 10/4/2010
7. Progress note by DO, dated 9/23/2010
8. Progress note by DO, dated 8/19/2010
9. Progress note by DO, dated 7/22/2010
10. Review summary by DO, dated 6/9/2010
11. Fax page dated 10/28/2010
12. Fax page dated 10/27/2010
13. Case assignment by, dated 10/27/2010
14. Independent review organization by Author unknown, dated 10/26/2010
15. Letter by MD, dated 10/21/2010
16. Letter by, dated 10/12/2010
17. Letter by dated 10/7/2010
18. Letter by dated 10/5/2010
19. Letter by dated 10/4/2010
20. Review organization by Author unknown, dated 10/2/2010

Name: Patient_Name

21. Letter by dated 9/30/2010
22. Letter by dated 9/30/2010
23. Letter by Author unknown, dated 8/26/2010
24. Form by Author unknown, dated 8/19/2010
25. Fax page dated 10/28/2010
26. Fax page dated 10/27/2010
27. Case assignment by, dated 10/27/2010
28. Independent review organization by Author unknown, dated 10/26/2010
29. Letter by MD, dated 10/21/2010
30. Letter by dated 10/12/2010
31. Letter by dated 10/7/2010
32. Letter by dated 10/5/2010
33. Letter by dated 10/4/2010
34. Review organization by Author unknown, dated 10/2/2010
35. Letter by dated 9/30/2010
36. Letter by dated 9/30/2010
37. Letter by Author unknown, dated 8/26/2010
38. Form by Author unknown, dated 8/19/2010

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a male who suffered right below knee amputation on xx/xx/xx due to injury on xx/xx/xx. Injured employee underwent completion/revision of amputation on 6.22.10 or 6.23.10. He had initial difficulties healing due to infection subsequently treated with hyperbaric oxygen treatments. Note by states the injured worker is completely healed. He is currently ambulatory with standard crutches. He is otherwise healthy and not limitations to ambulate with a prosthesis. Goals are for prosthesis fitting, gait training and return to regular duty. He is highly motivated and is expected to be a complete ambulator.

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

The right knee preparatory prosthesis is considered medically necessary for the injured employee. According to ODG, Criteria for the use of prostheses: A lower limb prosthesis may be considered medically necessary when: 1. The injured employee will reach or maintain a defined functional state within a reasonable period of time; 2. The injured employee is motivated to ambulate; and 3. The prosthesis is furnished incident to a physician's services or on a physician's order. The request for prosthesis meets all of these criteria. The injured employee is documented as being healthy, able to ambulate with crutches and skin is completely healed after wound care. There are no documented barriers to return to ambulatory state with a prosthesis. The injured employee is documented as highly motivated to ambulate and return to work regular duty and there is a physician's order for the prosthesis. An initial preparatory prosthesis in this otherwise healthy injured worker is most appropriate per the guidelines and would allow for return to regular duty work. The recommendation is to overturn the previous denial.

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

Name: Patient_Name

ODG Knee and Leg

Prostheses (artificial limb)