

# Becket Systems

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Nov/23/2010

**IRO CASE #:**

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

Urgent Replacement Above knee socket  
Urgent Test Socket Above Knee  
Urgent Above Knee Acrylic Socket  
Urgent Total Contact Above Knee  
Urgent Ischial Containment Narrow Socket  
Urgent Above Knee Flexible Inner Socket  
Urgent Suction Suspension Above Knee  
Urgent Socket Insert w/o Lock Mech  
Urgent Custom Shape Cover AK  
Urgent Ando AK Ultra-Light Material  
Urgent Endo Knee-shin Hydral Swg Ph  
Urgent Knee-shin sys Stance Flexion  
Urgent High Activity Knee Frame  
Urgent Vertical Shock Reducing Pylon  
Urgent Endoskeletal Axial Rotation  
Urgent Flew-Walk Sys Low Ext Prost  
Urgent Multiaxial Ankle w Dorsiflex

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

M.D., 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Official Disability Guidelines

10/7/10, 10/27/10

Orthopaedic Surgery Group 8/25/08-10/26/10

8/16/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male claimant with a history of a right above the knee amputation. A physician

record dated 08/16/10 noted the claimant having problems with the stump and the prosthesis not fitting well following treatment for a stump abscess. The claimant was noted to have an antalgic cadence. Due to the anatomic change and tissue shrinkage, the treating physician recommended a new above the knee amputation socket be made.

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

The requested prosthetic replacement is medically necessary. The claimant has a nearly three year-old prosthesis socket and reportedly had a limb revision surgical procedure to change the shape and size of the residual limb. The prosthetist has, according to the records, attempted to adjust the socket without success.

The reported difficulty with fit of the socket is causing pain for the claimant. The revision of the socket would therefore appear consistent with ODG guidelines that allow for a new prosthesis due to a changed shape of the residual limb. Therefore and based upon the Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Knee and Leg: Prostheses (artificial limb), the reviewer finds there is medical necessity in this case for:

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Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Knee and Leg: Prostheses (artificial limb)

Prosthetic knees are considered for medical necessity based upon functional classification, as follows

a) A fluid or pneumatic knee may be considered medically necessary for patients demonstrating a functional Level 3 (has the ability or potential for ambulation with variable cadence) or above.

b) Other knee systems may be considered medically necessary for patients demonstrating a functional Level 1 (has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence) or above.

Milliman Care Guidelines. Inpatient and Surgical Care 14th Edition: Lower Limb Prosthesis

**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)