

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Aug/27/2011

**IRO CASE #:**

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

Left lower extremity below knee prosthesis

**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**

ODG-TWC

Utilization review determination 07/20/11

Reconsideration/appeal of adverse determination 08/03/11

Progress notes 10/12/09 through 07/21/11

Operative note 02/06/09

Pathological report 02/06/09

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. He was injured after a fall from a ladder, resulting in a tibial fracture, with infected non-union and subsequent below the knee amputation performed 02/06/09. He was seen in follow up on 07/21/11. His chief complaint is stump pain. He is very active working 50 hours a week and having trouble with his prosthesis. It is hurting with ambulation. It is rubbing. He has had minor adjustments by the prosthetist, but due to remodeling of his stump it is not fitting properly. On examination there are abrasions and calluses forming over the medial and lateral aspect of the knee and stump. There were no open wounds. Denial dated 07/20/11 concluded that the request for left lower extremity below the knee prosthesis was not indicated as medically necessary. The reviewer noted the medical records had not thoroughly established the patient's current clinical status including subjective complaints and objective findings in a recent examination as well as physician's rationale for new prosthesis. Denial dated 08/03/11 determined that the reconsideration/appeal request for left lower extremity below the knee prosthesis was not indicated as medically necessary. It was noted that the patient sustained a tibial fracture and infected non-union with subsequent below the knee amputation. He has been working and very actively utilizing left lower leg prosthesis. It was noted that the prosthetist has made many adjustments to the prosthesis, but due to remodeling of the stump, the prosthetic was not fitting properly. The injured employee was noted to have significant pain with poor fitting

prosthesis. It was determined that a new left lower extremity below the knee prosthesis would not be considered medically necessary and appropriate based upon the records provided. The records document a significant issue related to the current prosthesis with continued pain around fibular head. An undated note from brace company documented the root of the problem is volume loss in residual limb. Pressure on distal end and fibular head is caused by residual limb falling deep into prosthetic socket. The brace company notes document that the only solution would be to replace the socket. It was unclear as to why entire left lower extremity prosthesis needs to be fabricated when replacement of the socket is what is required.

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

The injured employee is noted to have sustained a fracture of tibia. He underwent multiple operations. He had infected tibia nonunion resulting in below the knee amputation on 02/06/09. The injured employee has been using a below the knee prosthesis. He has experienced trouble with the prosthesis despite numerous minor adjustments. Due to remodeling of the stump, his prosthesis is not fitting properly. A previous review noted that socket replacement is required, but there is no medical necessity for replacement of entire lower extremity prosthesis. This reviewer agrees. There is no medical necessity for Left lower extremity below knee 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)