

US Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/14/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

purchase one (1) right knee off the shelf brace

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

M.D., Board Certified Orthopedic 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

Official Disability Guidelines

12/15/11, 12/23/11

Notice of employee's work-related injury/illness XX/XX/XX

Radiographic report 12/06/11

Office notes, 12/06/11, 10/02/11, 10/05/11, 10/19/11, 10/31/11, 11/22/11, 12/07/11

Handwritten rehab notes, 11/22/11-12/13/11

CT right lower extremity, 11/04/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. She slipped on a wet floor and fell to her knees, hitting her right elbow on the sink, and hearing a pop in the right knee. She was diagnosed with contusion of the knee, knee strain and contusion of right elbow. CT of the right lower extremity dated 11/04/11 revealed no fracture; small amount of fluid along the anterolateral aspect of the knee; subtle ligamentous injuries cannot be excluded with CT. No obvious ligament or tendon tears were seen on this exam. Orthopedic note dated 12/06/11 indicates that on physical examination there is normal alignment of the right lower extremity. Range of motion is functional, but with limited extension minus 10 degrees. There is no obvious dislocation, but she has increased abduction, instability and anteromedial rotatory instability up to 2+. She had an equivocal Lachman. Knee strength is 3/5. Straight leg raising is okay. The patient was recommended to undergo a course of therapy and was given a CT arthritic brace. Radiographic report of the right knee dated 12/06/11 is reported as normal. The patient underwent a course of 12 sessions of physical therapy. The request for knee brace was denied on 12/15/11 noting that x-rays are negative. No MRI studies, injections or surgery are documented. Treatment has included physical therapy. On exam, mild favoring of the right lower extremity was noted. Right knee range of motion was restricted to flexion due to pain. No other detailed physical examination findings for the knee

were documented. The denial was upheld on 12/23/11.

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

The patient was diagnosed with contusion of the knee and knee strain and completed 12 sessions of physical therapy. The ODG support knee brace for knee instability, ligament insufficiency/deficiency, reconstructed ligament, articular defect repair, avascular necrosis, meniscal cartilage repair, painful failed total knee arthroplasty, painful high tibial osteotomy, painful unicompartmental osteoarthritis and tibial plateau fracture. The submitted records fail to establish that the patient presents with any of the accepted conditions for which an off the shelf knee brace is supported. The reviewer finds no medical necessity exists for purchase one (1) right knee off the shelf brace.

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 KNOWLEDGBASE

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)