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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 7/24/14

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an above the right knee prosthesis L5321, L5624 (x3), L5650, L5920, L5950, L 5631, L5649, L5651, L5652, L5679 (X2), L5828, L5845, L5848, L5856. L5999, L8499, L5968, L5981, L5705, L5964, and L5999.

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

The reviewer is a Medical Doctor who is board certified in Orthopedics. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding an above the right knee prosthesis L5321, L5624 (x3), L5650, L5920, L5950, L 5631, L5649, L5651, L5652, L5679 (X2), L5828, L5845, L5848, L5856. L5999, L8499, L5968, L5981, L5705, L5964, and L5999.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed: 7/15/14 letter, provider usage document, 6/5/14 denial letter, 6/8/14 denial letter, 6/23/14 dial letter, 6/8/11 to 1/24/13 reports

9/8/14 script, notes 3/24/14, patient notes 4/24/14, 4/24/14 letter of Medical Necessity, and Prosthesis section from ODG.

6/13/14 letter, 3/29/14 SOAP note, 7/16/14 letter, 4/28/14 office notes, 4/24/14 service estimate, 4/24/14 patient notes, 4/24/14 examination notes, 6/5/14 denial letter, C-leg what is it paper,

A copy of the ODG was provided by the Carrier for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a diabetic has a history of having stepped upon a nail at work with a subsequent infection of the foot. The patient has a history of an above the knee amputation. There are complaints of an ill-fitting prosthesis in addition to the prosthesis being heavy and associated with back pain. Reportedly the prosthesis is not repairable and ill-fitting at the level of the socket. Prior denials evidence that the patient's functional status is estimated at a level 2 (limited community ambulation), although the requested prosthesis and attachments are typically for those at a level 3 (variable cadence ambulation). Reportedly an objective functional evaluation to assess as to if the patient would reasonably qualify for a functional level 3 prosthesis had not been performed. The patient also had a reported relatively secondary lifestyle. The 4-24-14 dated prosthetic evaluation indicated that the patient was a functional level 3. The 6-13-14 dated letter of medical necessity was reviewed.

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

Although there does appear to be an indication for replacement of the prosthesis; detailed analysis of the patient's overall lifestyle and functional level that at all evidences support for a functional level III have not been provided. Therefore, the request for essentially an upgraded prosthesis to correspond to a reported functional level III is not medically reasonable and/or necessary. Overall evidence of other than limited community ambulation has not been comprehensively provided in detail at this time.

Reference: ODG Knee Chapter; Prosthesis (Artificial Limb); Criteria for the use of prostheses:

A lower limb prosthesis may be considered medically necessary when:

1. The patient will reach or maintain a defined functional state within a reasonable period of time;
2. The patient is motivated to ambulate; and
3. The prosthesis is furnished incident to a physician's services or on a physician's order.

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, typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion), or above.

(b) A single axis constant friction knee and other basic knee systems are 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, typical of the limited and unlimited household ambulator), or above.

(c) A high-activity knee control frame is considered medically necessary for patients whose function level is 4. (has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete), or above.

(d) Microprocessor-controlled leg prostheses (e.g., Otto Bock C-Leg, Intelligent Prosthesis, and Ossur Rheo Knee) are considered medically necessary in otherwise healthy, active community ambulating adults (18 years of age or older) demonstrating a functional Level 3, or above, with a knee disarticulation amputation or a trans-femoral amputation from a non-vascular cause (usually trauma or tumor) for whom this prosthesis can be fitted and programmed by a qualified prosthetist trained to do so.

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)