AccuReview

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[Date notice sent to all parties]:
IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left Transtibial Prosthesis: L5301, L5704, L5962, L5620 x 2, L5367, L5910, L5940, L5629, L5668, L5679, L5683, L5972, L5666, L8420 x 18

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board certified in Orthopaedic Surgery with over 15 years of experience.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX: UR performed by XX. Prosthetic liners L5679, L5666 are determined medically necessary and certified.

XXXX: Final Report dictated by XX. CC: chronic pain. Impression: amputation of left lower extremity below knee, encounter for lifting and adjustment of partial artificial left leg, other abnormalities of gait and mobility, and phantom limb pain. Plan: EMS socket, waiting for authorization for new prosthetic.

XXXX: Clinic Therapy Equipment Prescription dictated by XX. PTB socket, custom tec liner, cuff suspension, variflex foot, supplies, safe ambulation, independent donning. We recommended the following as being medically necessary to allow the claimant to safely function at full potential. This equipment will help reduce long term costs associated with complications and/or hospitalizations/re-hospitalizations.

XXXX: UR performed by XX. Reason for denial: The claimant is a XX who has filed a claim for an XX reportedly associated with the industrial injury dated XXXX. The request is for left transtibial prosthesis. The ODG recommend that prostheses are indicated when employed to facilitate a claimant's reaching or maintaining a defined functional state in individuals who are motivated to ambulate. The attending provider's XXXX office visit suggested that the claimant already had an indwelling prosthetic, was capable of walking in the community, and that the prosthesis was well-fitting and well positioned. As such, the claimant already had an appropriately fitting and well-placed prosthetic that effectively obviated the need for the replacement device. Therefore, based on the guideline and medical information, the requested left transtibial prosthesis is not medically necessary.

XXXX: Letter of Reconsideration dictated by XX. The claimant does not have an "indwelling prosthetic". It is medically necessary for XX to obtain a new prosthesis using a custom cushion liner due to the skin grafts and irregular shape of

the residual limb. XX current prosthesis is XX and is not fitting optimally causing skin breakdown. We are requesting the same suspension (cuff suspension) as XX is able to functionally don and doff the components. XX is community ambulatory so a K3 level foot is medically reasonable and necessary.

XXXX: UR Performed by XX. Reason for denial: The ODG recommend that prostheses are indicated when employed to facilitate a claimant's reaching or maintaining a defined functional state in individuals who are motivated to ambulate. The previous report notes that the attending provider's office visit XXXX suggested that the claimant already had an indwelling prosthetic as they were capable of walking in the community; additionally, it was mentioned that the prosthesis was well-fitting and well positioned. The provider treatment notes indicate that the claimant currently has a prosthesis. There is r, dated XXXX that the residual limb has skin grafts and irregular shaped residual limb. However, there were not appreciable acute changes to the residual limb, acute injures or surgical procedures to the residual limb that would indicate acute changes to the skin integrity or wounds. There is no mentioned as to whether, or not, modifications have been trialed to the socket itself without the need of a whole new prosthesis. Attempts to clarify with the provider were not successful. Therefore, the request for left transtibial prosthesis is denied.

XXXX: Final Report dictated by XX. CC: prosthetic and rehabilitation evaluation, requesting new prosthesis or artificial limb current prosthesis is ill fitting, XX and causing skin breakdown with breakdown on skin from ill-fitting prosthesis. The claimant has significant skin grafting on his residual limb and has gained XX since XX prosthesis was fit. The current prosthesis is XX and had been modified by the prosthesis multiple times and now is not fitting well over the XX has had prior requests denied for unclear reasons. While XX can walk out in the community XX has one limb that is without injury. XX LUE is a shoulder disarticulation and XX inly has a thumb on right partial hand. XX has a significant risk for falls and has balance problems. XX skin becomes irritated if XX wears the prosthesis more than 3-4 hours at a time and needs to take it off frequently for skin checks. Over 50% of XX body has burns affecting XX skin. Approval for a prosthesis has never been issued in the past but has been increasingly difficult to communicate with the medical director for approval in the XX. The prosthesis will allow XX to be ambulatory. It is XX and does not fit as it is causing skin break down. Additionally, XX has a very short limb with skin grafts, so a very difficult socket fit particularly with recent weight gain. Denying XX a prescription more than XX post injury when XX has used one during that entire time does not make sense from a medical standpoint. If XX continues to have this denied XX will be relegated to a wheelchair and become more inactive with likely worsening weight gain and decline in health and quality of life. Impression and Plan: Amputation of left lower extremity below knee, Encounter for fitting and adjustment of partial artificial left leg, Other abnormalities of gait and mobility, Phantom limb pain.

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

The request for left transtibial prosthesis is denied. The claimant sustained a work-related injury in XXXX, which resulted significant skin burns and a left below knee amputation (BKA). The claimant is currently dealing with concerns of skin breakdown with XX current prosthesis. XX has an irregular stump with skin grafts. XX has had difficulty with XX socket fit with recent weight gain. XX current prosthesis is XX. The treating physician has requested a new prosthesis. The records indicate no episodes of acute skin breakdown, requiring complete discontinuation of the prosthesis. XX stump will always have an irregular fit, especially in the setting of prior skin grafts. The claimant should focus on weight loss to improve fit of XX current prosthesis, decrease XX energy expenditure with ambulation, and allow XX to be more ambulatory. Therefore, after reviewing the medical records and documentation provided, the request for Left Transtibial Prosthesis: L5301, L5704, L5962, L5620 x 2, L5367, L5910, L5940, L5629, L5668, L5679, L5683, L5972, L5666, L8420 x 18 is denied.

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)**