



Specialty Independent Review Organization

Date notice sent to all parties: 8/14/2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the concurrent medical necessity of a knee prosthesis for the left knee.

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 Physical Medicine and Rehabilitation.

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 the concurrent medical necessity of a knee prosthesis for the left knee.

PATIENT CLINICAL HISTORY [SUMMARY]:

This XXXX was involved in a XXXX. After many years of attempting to salvage the limb, XXXX underwent an above the knee amputation on the left on XXXX. XXXX has been using a prosthesis with mechanical knee. XXXX was provided a wheelchair/scooter in XXXX. XXXX ambulates with an assistive device. XXXX stands greater than 10 minutes. XXXX does not walk in the community. XXXX lives alone and has a caretaker. XXXX has phantom pain and uses opioids and gabapentin. XXXX has low back and neck pain. XXXX is overweight but has lost weight. The notes indicate XXXX is limited by fear of falling especially up and down ramps in the community. XXXX Pavet score is 60. There are no therapy notes to review.

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

This XX has been ambulating with a mechanical knee. The notes indicate XXXX is fearful of ambulating in the community. There are not notes indicating that has been addressed. XXXX still is having pain in the leg. The notes indicate that there was a problem with fit or function in the current prosthesis and that modifications were made. A recommendation is made for a new prosthesis indicating the patient has fear of falling in the community. A microprocessor-controlled knee is supported in an active healthy community ambulating adult. This claimant has multiple comorbidities including pain. XXXX has been using an assistive device for ambulation. XXXX has a wheelchair/scooter. XXXX has fear of falling that has not been addressed. The new prosthesis is not supported by the ODG; therefore, the request is not medically necessary.

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)**