

Clear Resolutions Inc.

An Independent Review Organization

7301 Ranch Rd 620 N, Suite 155-199

Austin, TX 78726

Fax: 512-519-7316

DATE OF REVIEW: NOVEMBER 30, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Surgery left total knee arthroplasty length of stay one day (CPT 27447, 20926, 0056Y)

A 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

Adverse Determination Letters, 10/9/07, 10/24/07

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Knee and Leg
Knee joint replacement

Office note, Dr., 01/22/07, 03/13/07, 04/09/07

Left knee MRI, 06/01/07

Note, 09/26/07

Knee evaluations, 10/10/07 and 10/24/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This female claimant reportedly has a several year history of left knee pain. The records indicated that the claimant underwent a left knee arthroscopy with partial lateral meniscectomy and chondroplasty of the patella in xx/xx/xx. Continued left knee complaints were reported. An MRI of the left knee performed on 06/10/07 showed grade II chondromalacia of the lateral and patellofemoral compartments and grade III in the medial compartment. The claimant treated conservatively with numerous anti-inflammatory medications, several injections and a series of Synvisc injections without benefit. A total knee replacement was recommended by the treating physician.

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

Left total knee arthroplasty appears to be medically necessary and appropriate.

This is a female who has status post arthroscopy. She has had persistent pain symptomatology in spite of arthroscopy, epidural steroid injections, Synvisc, Visco supplementation therapy, anti-inflammatory treatment, including Celebrex, Naprosyn, Mobic, and Vioxx, and radiographs which demonstrate varus deformity of the knee, medial joint space narrowing. Clinically, the motion is 15 degrees shy of full extension to 120 degrees, with patella grind. Based upon the conservative measures, findings, and persistent pain symptomatology, I think it is reasonable and appropriate to proceed with knee arthroplasty.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Knee and Leg
Knee joint replacement

ODG Indications for Surgery™ -- Knee arthroplasty:

Criteria for knee joint replacement (If only 1 compartment is affected, a unicompartmental or partial replacement is indicated. If 2 of the 3 compartments are affected, a total joint replacement is indicated.):

- 1. Conservative Care:** Medications. OR Visco supplementation injections. OR Steroid injection. PLUS
- 2. Subjective Clinical Findings:** Limited range of motion. OR Night-time joint pain. OR No pain relief with conservative care. PLUS
- 3. Objective Clinical Findings:** Over 50 years of age AND Body Mass Index of less than 35. PLUS
- 4. Imaging Clinical Findings:** Osteoarthritis on: Standing x-ray. OR Arthroscopy.

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)