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DATE OF REVIEW: July 17, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right total knee replacement with 5 day length of stay

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

Diplomate, American Board of Orthopaedic 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

Medical records from the Carrier include:

- M.D., 01/10/07, 01/24/07, 02/07/07, 02/21/07, 03/07/07, 03/21/07, 04/04/07, 04/18/07, 05/02/07, 05/16/07, 06/28/07
- M.D., 01/23/07
- Radiology, L.P., 02/13/07 & 03/15/07

Medical records from the URA include:

- **MRI Central, 01/04/07**
- **M.D., 01/10/07, 01/24/07, 02/07/07, 02/21/07, 03/07/07, 03/21/07, 04/04/07, 04/18/07, 05/02/07, 05/16/07**
- **M.D., 01/23/07**
- **Radiology, L.P., , M.D., 03/15/07**
- **Medical Equation 05/21/07**
- **M.D., 06/12/07**
- **06/13/07**

PATIENT CLINICAL HISTORY:

The records indicate that the patient was working when he was injured on. He was climbing stairs when his foot slipped and he developed pain and swelling on the medial side of his knee.

An MRI disclosed a tear of the medial meniscus. The patient's range of motion was 10 to 100 degrees. There was no evidence of instability.

M.D. subsequently recommended an arthroscopy. On January 23, 2007, an excision of the torn medial and lateral menisci was performed arthroscopically by Dr.. The patient developed calf pain following the surgery; however, there was no evidence of deep venous thrombus.

A repeat MRI was subsequently performed on March 15, 2007. The patient had prominent chondromalacia and a re-tear of the medial meniscus fragment.

The patient returned to Dr. who recommended a repeat arthroscopy. The repeat surgery was performed on April 3, 2007. Subsequent to that, physical therapy was prescribed, however, the patient continued to have crepitation, and x-rays disclosed significant tricompartmental disease.

A request for a total knee arthroplasty was subsequently made on May 16, 2007. Dr. noted that the patient had undergone injections, as well as multiple arthroscopies and physical therapy with continued symptoms. Another injection was performed on May 16, 2007.

The peer reviewer, M.D., indicated that the records did not reflect that the patient met criteria for a total knee replacement because further information was indicated.

There was another peer review performed by M.D. He indicated that the request for surgery was not supported as radiographs did not indicate the degree of osteoarthritis.

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

It is my opinion that the total knee replacement being requested is not supported according to the ODG Guidelines because of incomplete information. In this case, the patient does have limited range of motion and night pain and has undergone conservative care. The medical records do not indicate the patient's body mass index, and therefore, for lack of this information a total knee replacement cannot be recommended as medically necessary according to the ODG Guidelines.

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)