Independent Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Phone: 817-235-1979
Fax: 817-549-0311

DATE OF REVIEW: June 25, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Post-operative two rental of continuous passive motion unit

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

Board Certified

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRI left knee, xx/xx/xx
Office note of Dr., 04/12/07
Request for left knee arthroplasty, 05/16/07
Peer review 05/17/07 and 05/21/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male diagnosed with degenerative osteoarthritis of the left knee. The MRI on 05/05/07 demonstrated a posterior medial meniscus tear and advanced degenerative arthritis. Standing x-rays on 04/12/07 revealed Kellgren-Lawreence IV degenerative arthritis of the left knee. The plan of treatment included rest, ice and anti–inflammatories. A request for left knee arthroplasty was submitted on 05/16/07.

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

Based on the information provided for review, the previous adverse determination for the request of the rental of a continuous passive motion device is upheld. The records indicated a request for left total knee arthroplasty was submitted on 05/16/07. It is unclear if the requested surgery has been approved and therefore the need for a continuous passive motion device cannot be determined. According to the Official Disability Guidelines, the claimant does not meet the current criteria for use of this device.

Official Disability Guidelines Fifth Edition Treatment in Worker's Comp 2007 Updates, Knee

Criteria for the use of continuous passive motion devices:

May be considered medically necessary for up to 21 days postoperatively for the following surgical procedures:

1. Total knee arthroplasty
2. Anterior cruciate ligament reconstruction
3. Open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint

Milliman Care Guidelines 11th Edition

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**
  - Milliman Care Guidelines 11th Edition
- ☒ **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)**