



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Notice of Independent Review Decision

DATE OF REVIEW: 12/04/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient left total knee arthroplasty

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

Board Certified in Orthopedic 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)

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.

Inpatient left total knee arthroplasty - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An evaluation with M.D. dated 01/04/99
Evaluations with M.D. dated 01/06/99, 01/21/99, 02/18/99, 03/04/99, 03/19/99,
04/08/99, 05/03/99, 05/26/99, 06/11/99, 06/16/99, 06/17/99,

06/24/99, 07/08/99, 07/22/99, 08/12/99, 09/10/99, 10/08/99, 10/25/99, 10/29/99, 11/04/99, 12/02/99, 12/16/99, 01/24/00, 02/24/00, 02/14/02, 03/04/02, 01/16/03, 09/30/04, 11/04/04, 01/03/05, 01/20/05, 06/21/07, 03/17/08, 04/28/08, 09/12/08, and 09/22/08

Laboratory studies dated 06/07/99

An MRI of the left knee interpreted by M.D. dated 01/13/05

An MRI of the left knee interpreted by M.D. dated 10/10/07

An Adverse Determination Letter from L.V.N. dated 09/11/08

An Adverse Determination Letter from R.N. dated 10/24/08

A reconsideration letter from Ms. dated 11/17/08

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 01/04/99, Dr. recommended arthroscopic knee surgery. On 05/26/99, Dr. recommended another possible surgery, as well as Celebrex and Tylenol #3. On 06/24/99, Dr. recommended a continuous passive motion (CPM) machine. On 08/12/99, Dr. recommended a one year membership to the YMCA for therapy two to three times a week. On 02/24/00, Dr. placed the patient at Maximum Medical Improvement (MMI) at that time with a 13% whole person impairment rating. On 02/14/02, Dr. placed the patient in lateral wedges and placed him back on Celebrex, as well as on Ketoprofen cream. On 09/30/04, Dr. recommended Celebrex, Cosamine, Ketoprofen cream, Zostrix cream, and orthotics with a quarter inch heel lift. An MRI of the left knee interpreted by Dr. on 01/13/05 revealed attenuation of the medial meniscus that might represent post meniscectomy change and a joint effusion with chondromalacia patellae. On 06/21/07, Dr. performed a steroid injection to the knee and also requested an arthroplasty, Celebrex, Ultram ER, Glucosamine, Ketoprofen cream, and Nexium. An MRI of the left knee performed on 10/10/07 and interpreted by Dr. revealed postoperative changes, suspicions for an element of arthrofibrosis versus an occult macerated displaced meniscal fragment, and mild osteoarthritis with a full thickness cartilage defect at the medial margin of the medial tibial plateau. On 03/17/08, Dr. again performed a steroid injection to the knee. On 09/11/08, Ms. wrote a letter of adverse determination for a total knee replacement. On 10/24/08, Ms. provided a letter of adverse determination for the knee replacement. On 11/17/08, Ms. provided a reconsideration letter for the knee replacement.

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

Based on the records reviewed, it appears that the patient has full thickness loss of cartilage in the medial joint and in the patellofemoral joint. This is certainly a difficult problem to have status post reconstruction of the anterior cruciate ligament. Unfortunately, this is not terribly uncommon. However, in a young patient a total knee replacement would not be recommended. Thus, is it my

opinion that the requested inpatient left total knee arthroplasty is not reasonable, necessary, or supported by the ODG.

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 AND KNOWLEDGE BASE
- 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)