

RYCO MedReview

Notice of Independent Review Decision

DATE OF REVIEW: 03/04/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Inpatient right total knee replacement

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 right total knee replacement - Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 06/25/99, 08/03/99, 09/10/99, 10/22/99, 11/17/99, 12/08/99, 12/29/99, 01/27/00, 06/12/00, 07/24/00, 09/28/00, 10/03/00, 11/28/00, 12/20/00, 03/12/01, 08/20/01, 12/04/01, 02/11/02, 03/06/02, 04/10/02, 04/29/02,

05/20/02, 06/10/02, 07/08/02, 08/05/02, 09/03/02, 10/07/02, 12/09/02, 02/17/03, 04/07/03, 04/28/03, 06/26/03, 08/06/03, 09/17/03, 11/19/03, 01/19/04, 09/13/04, 11/28/05, 02/20/06, 07/31/06, 10/09/06, 11/06/06, 12/18/06, 02/19/07, 06/19/07, and 10/22/07

MRIs of the bilateral knees interpreted by M.D. dated 02/22/02

Operative reports from Dr. dated 04/02/02 and 09/28/06

A pathology report interpreted by M.D. dated 09/28/06

A letter of non-certification, according to the ACOEM and ODG, dated 01/25/08

A letter of non-certification, according to the ODG, from M.D. dated 02/13/08

An invoice dated 02/27/08

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

PATIENT CLINICAL HISTORY [SUMMARY]:

On 08/03/99, Dr. placed the left knee in a wraparound brace and recommended physical therapy three times a week for four weeks. On 10/22/99, Dr. placed the patient at Maximum Medical Improvement (MMI) for the left knee. On 11/17/99, Dr. recommended left knee surgery. On 01/27/00, Dr. recommended advanced work hardening. On 10/03/00, Dr. assigned the patient a 10% whole person impairment rating for both knees. On 11/28/00 and 12/04/01, Dr. performed a right knee injection and aspiration. An MRI of the left knee interpreted by Dr. on 02/22/02 revealed degenerative changes in the knee with a moderate effusion and Baker's cyst. An MRI of the right knee interpreted by Dr. on 02/22/02 revealed moderate degenerative changes with mild joint effusion and a meniscal cyst. On 04/02/02, Dr. performed a right tibial osteotomy. On 06/10/02, Dr. recommended continued physical therapy. On 12/09/02, Dr. performed an injection and aspiration of the right knee. On 02/17/03, Dr. recommended left knee surgery. On 04/07/03, Dr. recommended continued use of a continuous passive motion machine. On 09/13/04, Dr. prescribed Hydrocodone and Vioxx. On 11/28/05, Dr. recommended a new knee brace. On 09/28/06, Dr. performed a left total knee arthroplasty. On 11/06/06, Dr. recommended continued physical therapy. On 10/22/07, Dr. recommended a right total knee replacement. On 01/25/08, wrote a letter of non-certification for the right total knee replacement surgery. On 02/13/08, Dr. also wrote a letter of non-certification for the right total knee replacement surgery.

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

In my opinion, the total knee replacement is reasonable and necessary. The claimant had multicompartmental degenerative disease for sometime and failed conservative management. Per the ODG, this claimant would then qualify for a total knee replacement. Administratively, it seems to have picked up as compensable and thus, I believe surgery is 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)