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## Notice of Independent Review Decision

**DATE OF REVIEW:** 08/12/09

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Inpatient (4 day length of stay) Right Total Knee Replacement

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

Certified by the American Board of Orthopaedic Surgery

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	715.26	27447	Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Letter dated 7/29/09

Physician/Practitioner notes from 7/25/07 through 6/26/09

Operative note dated 7/10/07, 7/17/08

MRI reports dated 6/2/09, 4/9/08, 5/8/07

Treatment history

Official Disability Guidelines provided-Knee & Leg (Acute & Chronic)-Knee joint replacement

**PATIENT CLINICAL HISTORY:**

This claimant injured his right knee while lifting concrete forms on xx/xx/xx. The patient is status post right knee examination under anesthesia, arthroscopy with excision of torn portions of lateral meniscus, excision of loose bodies, debridement and chondroplasty of the patella. Records indicate the patient was treated with post operative therapy but the patient was non compliant. He continued to have pain and subsequently underwent a cortisone injection. MRI of the right knee dated 04/09/08 reported no evidence of cruciate or lateral ligament tear; no displaced meniscal tear; areas of severe chondromalacia in the patella and chondromalacia in the medial joint compartment greater than lateral. MRI of the right knee dated 06/02/09 was compared to MRI of the right knee dated 04/09/08. There was chondromalacia patella with areas of full thickness cartilage loss in the lateral facet and also chondromalacia of the medial facet. There also is chondromalacia in the opposing trochlear groove, which was present to some degree on 04/09/08 and has not greatly changed in appearance.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

In the Reviewer's opinion, the clinical data as presented does not support the medical necessity for the proposed surgical procedure and with a 4-day inpatient stay. The patient is noted to have undergone arthroscopic surgery in 07/2007. The Reviewer noted the patient's BMI exceeds that recommended by Official Disability Guidelines for the proposed procedure.

Reference:

**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. AND (Visco supplementation injections OR Steroid injection). PLUS
- 2. Subjective Clinical Findings:** Limited range of motion. AND Nighttime joint pain. AND 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. ([Washington, 2003](#)) ([Sheng, 2004](#)) ([Saleh, 2002](#)) ([Callahan, 1995](#))

**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)