

SENT VIA EMAIL OR FAX ON  
Aug/17/2009

## Applied Assessments LLC

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/13/2009

**IRO CASE #:**

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

Left Total Knee Arthroplasty

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

Board Certified Orthopedic Surgeon

**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**

OD Guidelines

Dr. OV 03/10;06 , 04/21/06 , 02/26/09, 05/28/09 , 07/06/09

Dr. 07/01/09

Computerized Muscle Testing 05/28/09 , 07/06/09

Pre Authorization Report 07/13/09 , 07/23/09

X-ray right foot , left knee , right hip and pelvis , right shoulder ? 02/26/09

CT right foot 06/09/09

MRI left knee 06/11/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a xx-year-old female claimant who reportedly tripped over a mop at work on xx/xx/xx and sustained injuries to her left knee, right hip, right foot and right shoulder. The records indicated that the claimant was initially diagnosed with a left knee strain, trochanteric bursitis of the right hip, right shoulder impingement and right foot sprain.

Physician records of 2006 noted the claimant with a history of left knee pain after an injury and MRI findings of a medial meniscal tear and large joint effusion. The claimant reportedly underwent a left knee arthroscopy and meniscotomy and lateral release on 04/05/06.

Ongoing left knee pain was reported. A 06/11/09 left knee MRI revealed tricompartmental arthritic changes with evidence of a prior partial lateral meniscectomy and anterior cruciate ligament deficiency. Osteoarthritis of the left knee was diagnosed. Conservative treatment included medications, physical therapy, injections, and modified activity with noted ongoing pain. A left total knee arthroplasty was recommended.

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

Left total knee arthroplasty is medically indicated and appropriate in this xx-year-old female who has had medications and injections. She has decreased range of motion and objective pain in spite of conservative measures. She is over xx years of age. She has arthritis on radiograph. Based on these parameters, surgery is indicated and appropriate.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates, Knee and Leg :  
Knee joint replacemen

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). PLU
2. Subjective Clinical Findings: Limited range of motion. AND Nighttime joint pain. AND No pain relief with conservative care. PLU
3. Objective Clinical Findings: Over 50 years of age AND Body Mass Index of less than 35. PLU
4. Imaging Clinical Findings: Osteoarthritis on: Standing x-ray. OR Arthroscopy.

#### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)