

**CORE 400 LLC**  
240 Commercial Street, Suite D  
Nevada City, California 95959

Notice of Independent Review Decision

**DATE OF REVIEW: JANUARY 5, 2009**

**IRO CASE #:**

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

27447 Total Knee Arthroplasty; ONEIA; Non Emergency Inpatient (3 units)

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

MD, 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)

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.

The reviewer finds that medical necessity exists for 27447 Total Knee Arthroplasty; ONEIA; Non Emergency Inpatient (3 units).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 11/17/08, 12/05/08  
ODG Guidelines and Treatment Guidelines  
MRI left knee, 6/12/08  
Left knee X-ray, 6/12/08  
Office note, Dr. , 7/28/08, 09/15/08

Office note, Dr. , 09/22/08  
Office note, Dr. 11/11/08  
Office note, 11/25/08  
TKR Literature, undated

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a xx-year-old male with a history of bilateral knee surgery in xxxx following a motor vehicle accident. On 05/21/08, he reportedly developed left knee pain after pushing a heavy work stand. Treatment included activity modification, therapy, NSAIDs, steroid injections and a series of viscosupplementation that provided two weeks of relief. Left knee pain with medial joint line tenderness, effusion and patellofemoral crepitus persisted. MRI noted meniscal degeneration without evidence of a tear, advanced cartilage loss in the medial femoral condyle, an effusion and a large Baker's cyst in the popliteal fossa. Left knee x-rays noted cartilage loss in the medial femorotibial joint space with bilateral subluxation and arthritic changes involving the patella. Left total knee replacement was recommended.

Dr. saw the claimant in consult on 11/11/08. Extension was full with flexion to 120 degrees. Medial joint line pain persisted and the Baker's cyst was palpable on exam. The impression was medial compartment degenerative joint disease with some patellofemoral wear. A unicompartmental replacement was recommended with conversion to a total knee if indicated at the time of surgery. The request was non-certified. Dr. noted in a letter on 11/25/08, the lateral compartment of the claimant's left knee was pristine and therefore he recommended a unicompartmental replacement with the option of converting to a total knee arthroplasty if indicated. The request was again non-certified and was submitted for another review.

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

The requested total knee replacement would seem reasonable based on the information reviewed. The claimant has significant arthritic change of both the medial and patellofemoral compartments according to x-rays and MRI. The claimant has failed treatment with medications and injections. The claimant failed both corticosteroid injections as well as viscosupplementation with Synvisc. A total knee arthroplasty would seem to be appropriate treatment for this xyear old who has at least bicompartamental disease, which has failed conservative measures. The claimant meets appropriate ODG criteria for the surgery. The reviewer finds that medical necessity exists for 27447 Total Knee Arthroplasty; ONEIA; Non Emergency Inpatient (3 units).

Official Disability Guidelines Treatment in Worker's Comp, 2009 Official Disability Guidelines, 14<sup>th</sup> edition, Knee and Leg

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)