

SENT VIA EMAIL OR FAX ON
Oct/26/2009

IRO Express Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/25/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpatient (3) day length of stay for left total knee replacement

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

Office note, Unknown provider, 07/18/06, 02/06/07, 9/14/07,

X-rays left knee, 07/18/06

MRI left knee, 07/26/06

Operative report, Dr. 08/04/06

Office notes, Dr. 08/21/06, 09/20/06, 10/04/06, 12/20/06, 10/31/07

DDE, Dr. 08/11/08

Left frontal and lateral views, 08/07/08

Record review, Dr. 12/11/08

Impairment rating, Dr. 04/29/09

Letter and disability review, Dr. 07/01/09

Office note, Dr. 08/19/09

Peer review, Unknown provider, 09/21/09

PATIENT CLINICAL HISTORY SUMMARY

This is a diabetic male who was status post xx/xx/xx arthroscopy with debridement medial

femoral condyle and debridement torn medial meniscus. The claimant was 6'2 inches and weighted 340 pounds. The 08/19/09 x-rays showed moderate varus deformity with bone on bone on the outer edge of the medial tibial plateau femoral component along with osteophytes. The 09/14/09 examination showed range of motion from 15 to 62 degrees. The claimant has been treated in the past with aspirations, injections, light duty and bracing.

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

In turning to the medical records in this case, it would certainly appear that conservative care is failing. The failure of medication and injection has been documented. Limited range of motion has been documented, as has nighttime pain. Osteoarthritis has been documented.

Unfortunately, this claimant is quite obese with a body mass index of 43.4. This factor would not satisfy the ODG guidelines for medical necessity.

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, chapter knee
-ODG Indications for SurgeryTM -- 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](#))

Milliman Care Guidelines, Inpatient Surgery, 13th Edition

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)