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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/26/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral knee arthroplasty with inpatient LOS 3 Days, 27447

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

M.D., 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

ODG Guidelines

Records review, Dr. 5/26/09

Addendum, Dr. 7/8/09

Peer review letters, 7/27/09, 08/17/09

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with complaints of bilateral knee pain following a fall on xx/xx/xx. The clinical information provided was from an examination on 05/26/09 with Dr. His record review noted MRIs of both knees on 11/19/08 that showed advanced degenerative changes in the medial compartment of the right knee, moderate to advanced in the left knee with moderate bilateral effusions. There was an intraarticular loose body in the left knee and a noted prior partial meniscectomy of the medial meniscus in the right knee. The records indicated the claimant underwent steroid injections and viscosupplementation to both knees in March of 2009. Examination on 05/26/09 noted positive apprehension testing in both knees with medial joint line tenderness and mild medial collateral ligament instability. Extension in the left knee was minus five degrees with flexion in left knee to 105 and in the right to 115 degrees. The impression was osteoarthritis in both knees. Bilateral total knee arthroplasty was recommended with a three-day length of stay.

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

The records in this case do not clearly outline the provision and failure of conservative care which could include steroid injections and viscosupplementation injections. There is no recent physical examination. There is no recording of height and weight to allow for a body mass index calculation. The information supplied would not satisfy the ODG guidelines for arthroplasty. The reviewer finds that medical necessity does not exist at this time for Bilateral knee arthroplasty with inpatient LOS 3 Days, 27447.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2009 updates, 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)

Milliman Care Guidelines®, Inpatient and Surgical Care, 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)