

Clear Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/23/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

LT total knee arthroplasty

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 Knee and Leg Chapter, ODG Indications for Surgery, Knee arthroplasty

Corporation, 7/20/10, 7/27/10

Orthopedics 2/19/09 - 7/26/10

Spine Institute 3/7/10

Wellness Clinic 8/19/08 - 11/25/09

Pain & Injury Relief Center 1/9/08

Clinic 7/17/07 - 11/27/07

Chiropractic Center 6/1/07

Podiatry 5/29/08

M.D. 4/24/07

Diagnostic 7/6/10, 6/1/10, 2/19/09

MRI & Diagnostic 5/20/10

Medical 5/20/10

Imaging Center 3/21/07

Radiology 2/7/06

Clinical Guide (no date)

Surgery 5/21/08, 2/20/08

Hospital 9/24/07

Medical Center 10/2/06

4/30/10

Orthomed 6/23/10

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who has undergone previous medial meniscectomy in 2007 and continues to complain of left knee pain. He has been treated with anti-inflammatory medication, physical therapy, and at least one steroid injection. X-rays were taken of the left knee, and the report reveals that there is severe medial tibiofemoral joint space loss, mild lateral tibiofemoral joint space loss, and moderate patellofemoral joint space loss. There is right pain, and the patient has failed to respond at this time to any conservative care.

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

Per the ODG Guidelines this patient has had conservative care, medications, and steroid injections. The patient has documented limited range of motion in the medical records along with documented nighttime joint pain, and no relief with conservative care. The patient is over years of age and has a body mass index of less than 35. The imaging studies show osteoarthritis on standing x-ray. This patient does meet the Official Disability Guidelines and Treatment Guidelines criteria for knee arthroplasty. It is for this reason the previous adverse determination is overturned. The reviewer finds that there is medical necessity for LT total knee arthroplasty.

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)