
MEDRx

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Notice of Independent Review Decision

DATE OF REVIEW: 7/5/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a knee arthroplasty (left).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a knee arthroplasty (left).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was noted to have injured her left knee in a fall xxxxx. The original diagnosis was that of a bilateral knee contusion. Exam findings have included a stable knee with a mild effusion, along with motion from 0-100 degrees. The claimant has been noted to walk with an antalgic limp without an assistive device. The claimant has been documented to have tri-compartmental osteoarthritis of the left knee and has been considered for a left knee replacement arthroplasty. An xxxxx dated MRI has revealed that the medial compartment is dramatically involved with cartilage loss and a meniscal tear, as compared to the other compartments of the knee. The claimant had a positive patellar grind and was noted to have post-traumatic chondromalacia as of xxxx. Therapy records from the xxxx facility were reviewed. The knee was injected with cortisone and considered for an unloader brace as of 9/16/09 and therapy was considered as of xxxxx. Denial letters emphasized the claimant's age, lack of known or documented BMI and lack of evidence of a comprehensive prior non-operative program. The claimant has been considered for a knee replacement procedure.

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

The reviewer states that without specific evidence of a failure of the considered unloader knee brace, and, without evidence of a trial and failure of viscosupplementation, the claimant does not fit criterion to warrant a surgical knee replacement. In addition, the claimant has not had documentation of a BMI that fits the criteria (less than 35) for a knee replacement, in addition to being under age 50 which is also a criterion for knee replacement.

Reference: ODGuidelines ODG Indications for SurgeryTM -- Knee arthroplasty:

Criteria for knee joint replacement (If only 1 compartment is affected, a unicompartmental or partial replacement may be considered. 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, where increased BMI poses elevated risks for post-op complications. PLUS
- 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- 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)