

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** May/26/2010

**IRO CASE #:**

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

Left total knee replacement 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

Official Disability Guidelines Treatment in Workers' Compensation, Knee & Leg  
3/3/10, 2/19/10, 5/18/10  
M.D. 2/10/10, 3/1/10, 3/22/10  
Orthopaedic Associates 3/11/09  
7/8/08, 8/19/08, 8/25/08  
2/24/10, 9/21/09, 12/21/09, 2/24/10  
9/4/08, 4/3/09, 12/4/09  
Solutions 10/23/08, 2/10/09  
Spine Clinic 1/8/09  
2/6/09  
Healthcare Group 2/11/09 to 4/23/10  
M.D. 3/24/09  
M.D. 6/11/09  
M.D. 8/6/09, 12/17/09  
MD, 5/6/10

### PATIENT CLINICAL HISTORY SUMMARY

This is a patient who had a reported injury from xx/xx/xx. He has had bracing and intraarticular injections. X-rays that show he has bone-on-bone in the medial compartment. He also has severe degenerative changes in the patellofemoral joint. He has varus secondary to the bone loss. He has had a remote anterior cruciate ligament reconstruction. He is age. Range of motion is 5 degrees to 110 degrees from the medical records.

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

This gentleman, with bone-on-bone changes, failure of conservative treatment, with limited

range of motion, certainly would meet medical necessity guidelines for total knee arthroplasty under the ODG indications for surgery. According to ODG, "overall, total knee arthroplasties were found to be quite effective in terms of improvement in health-related, quality-of-life dimensions." The patient meets all the criteria for this procedure. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned. The reviewer finds that medical necessity exists for Left total knee replacement 27447.

**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)