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Notice of Independent Review Decision

DATE OF REVIEW: 03/10/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The services under review include the medical necessity of a total knee arthroplasty (27447) and leg surgery procedure (27599).

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 15 years in this field.

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 medical necessity of a total knee arthroplasty (27447) and leg surgery procedure (27599).

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:
MD and Services.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: 12/1/09 to 1/18/10 reports by Dr., 9/14/09 report by MD, 12/1/09 report by Therapy, 10/15/09 right knee MRI report, 2/10/10 denial letter from carrier, AAOS guideline and 1/27/10 denial letter.

JI: 1/27/10 report by MD, 2/10/10 report by DO, 9/14/09 radiology report, 9/14/09 to 12/7/09 reports by MD, 10/7/09 PT eval, 12/2/09 to 12/22/09 PT daily eval

notes, daily progress notes from Pain and Recovery Clinic 9/21/09 to 12/14/09, 9/10/09 form 1 and various DWC 73 reports.

We did not receive the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:
The 2/10/10 dated denial letter was reviewed. The was noted to have sustained a twisting injury to the right knee on x/x/xx. The x-rays had not been provided and there was no evidence of a failure of viscosupplementation. A 1/27/10 dated denial review letter was in itself reviewed. The denial was based on the lack of opinion from the designated doctor and the lack of evidence of a trial and/or failure of viscosupplementation.

Progress notes from a Dr. were reviewed, including from 1/18/10 and prior. The notes included the above clinical findings and a diagnosis of post-traumatic arthritis. The BMI was noted to be 33.3 and the claimant was felt to have failed non-op. treatment and to have an indication for knee replacement arthroplasty. On 1/18/10, the claimant was noted to be walking with a cane, had an effusion, crepitus, joint tenderness and pain on stress. The claimant reportedly had failed medications, cortisone and bracing.

Records from a Dr. (dated 9/14/09) were also reviewed, with a diagnosis of internal derangement. Therapy records were reviewed and dated 12/1/09. The 9/14/09 dated x-ray report denoted "well-maintained" joint spaces.
A 10/15/09 dated MRI report denoted tricompartmental degenerative arthritic changes. 12/1/09 dated x-ray revealed severe osteoarthrosis medially with spurs.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
Post injury date of xx/xx/xx, the claimant has not been documented to have failed a comprehensive program of reasonable non-operative treatment such as physical therapy and viscosupplementation. The intent of the guidelines mandates the preceding prior to an invasive procedure such as surgical replacement of the knee joint. In addition, there is an apparent discrepancy between the xx/xx/xx dated x-rays and the other x-rays and or MRI re. the degree of joint space involvement/osteoarthrosis. The below findings are not met; therefore, the procedure is considered to not be medically necessary at this time based upon the records provided.

Reference: 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.

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)**